Rhode Island
State Innovation Model (SIM) Test Grant

Better Health, Better Care, and Lower Cost

Operational Plan

Version 2
May 31, 2016

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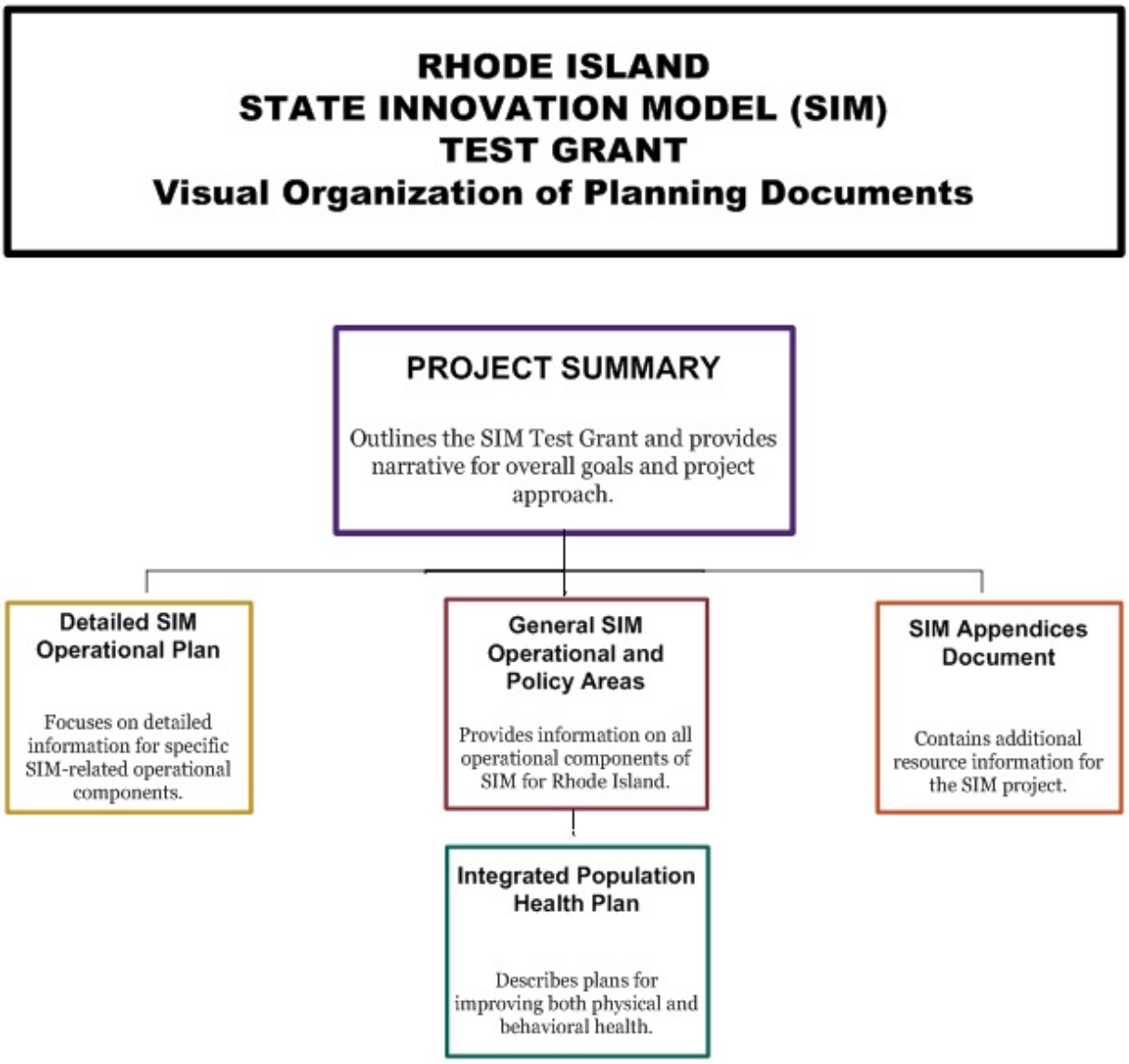
Visual Organization of the Operational Plan



A. Project Summary

This section outlines Rhode Island's SIM Test Grant, provides a narrative for the overall goals and project approach, and contains the following five areas: project narrative, driver diagram, core progress metrics and accountability targets, master timeline, and budget summary table.

Project Narrative

Overview

Rhode Island's history of health reform is impressive. We have been innovators, with expansion of Medicaid for children and their parents in the 1990's; steadfast, in our commitment to build on the market reforms and coverage expansions of the Affordable Care Act; and bold, as we embrace the task of multi-payer delivery system transformation and payment reform as the next crucial step in building a health care system that produces higher quality care, better health, and lower cost.

When we received the State Innovation Model Test Grant, we were excited about the opportunity that the dollars and the project structure gives us to take real strides for change while building on our history of reform.

Our challenge is to take this opportunity and use its component parts – the ability to tie our projects to specific metrics for planning and program implementation, the convening function that SIM gives us, and the ability to use our SIM staff and participants to make intentional connections between the related federal and state initiatives aiming at reform – to make more significant change than any of the reform efforts could do alone.

Vision

The vision of the Rhode Island SIM Test Grant represents the desired future state resulting from a transition to value-based care in the state. Our vision statement, borrowed from the Triple Aim, reads:

> *Continuously improving Rhode Islanders' **experience of care** (including quality and satisfaction), enhancing the **physical and behavioral health** of all Rhode Island's population, and **reducing the per capita cost** of healthcare for our residents.*

Mission

The mission of the Rhode Island SIM Test Grant is to significantly advance progress towards making this vision a reality. To accomplish this, the SIM Steering Committee has adopted the following mission statement:

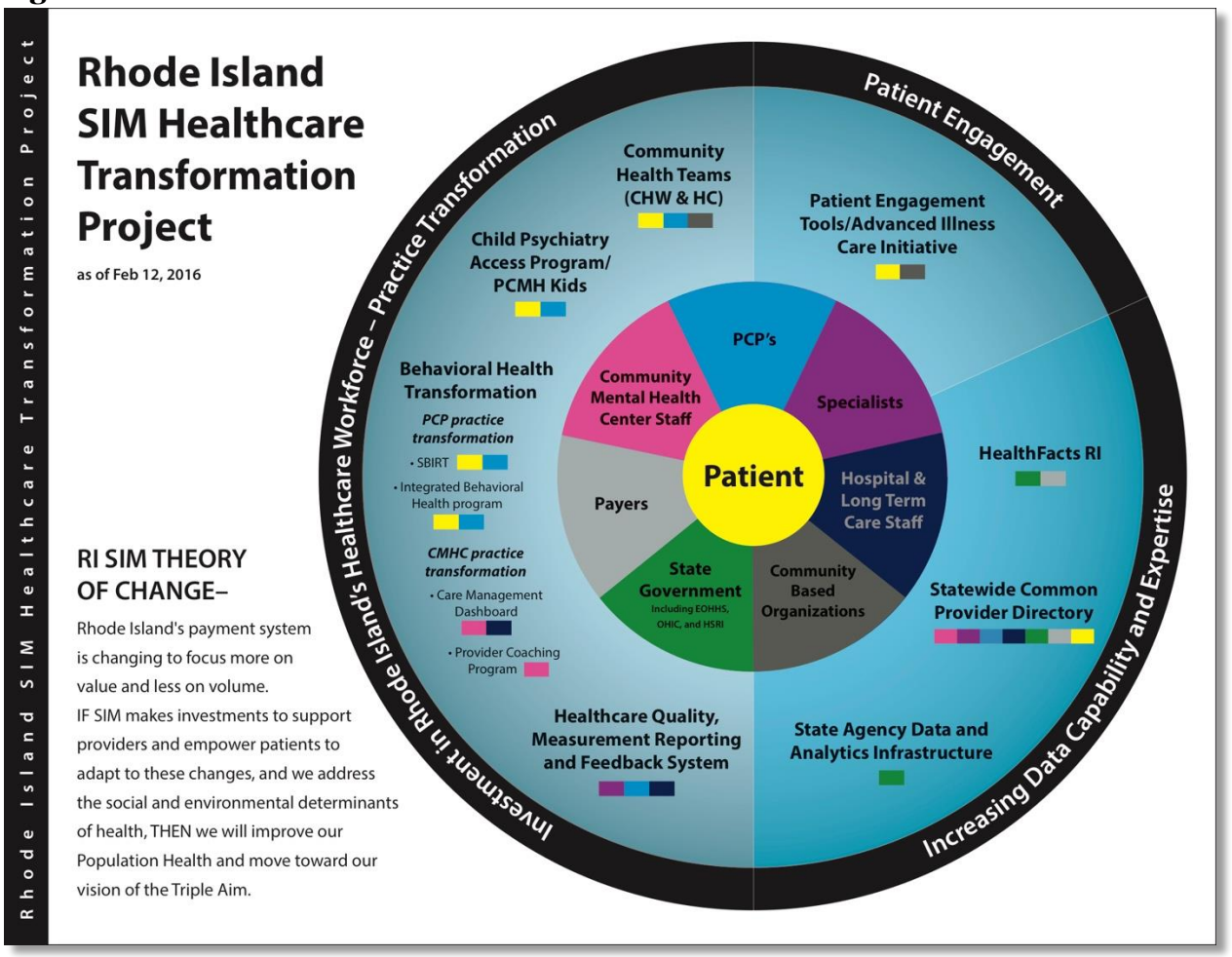
> *Rhode Island SIM is a multi-sectoral collaborative, based on data–with the patient/consumer/family in the center of our work. Rhode Island SIM is committed to an integrated approach to the physical and behavioral health needs of Rhode Islanders, carried out by moving from a fee-for-service healthcare system to one based on value that addresses the social and environmental determinants of health. Our major activities will provide support to the healthcare providers and patients making their way through this new healthcare system. We are building the system upon the philosophy that together—patients, consumers, payers, and policy makers–we are accountable for maintaining and improving the health of all Rhode Islanders.*

SIM Theory of Change

Rhode Island's payment system is changing to focus more on value and less on volume. IF Rhode Island SIM makes investments to support providers and empower patients to adapt to these changes, and we address the social and environmental determinants of health, THEN we

will improve our population health and move toward our vision of the "Triple Aim." The Transformation Wheel below depicts our aspiration within our Rhode Island SIM Test Grant:

Figure 1: Rhode Island SIM Transformation Wheel



SIM Health Transformation Strategies: SIM's approach to healthcare system transformation combines aspiration and pragmatism, as we align the state's current move away from fee-for-service to value based purchasing with practice transformation and a focus on integrated population health. Rhode Island's SIM Test Grant is built on the premise that transitioning to healthcare payment models that reward value, as opposed to volume, and incentivize providers to work together, is a necessary step toward building a sustainable healthcare delivery system that:

- Promotes high quality, patient-centered care that is organized around the needs and goals of each patient;
- Drives the efficient use of resources by providing coordinated and appropriate care in the right setting; and
- Supports a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of the social determinants of health.

Details of these three strategies are woven throughout the SIM Operational Plan.

Transformation Components: The following core elements of Rhode Island's Healthcare Delivery System Transformation Plan provide a roadmap for achieving the strategies listed above.

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value.

2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
    i. *Investment in practice transformation & development of the healthcare workforce:* These investments in training, coaching, and technology improvements aim to add to the skills and resources of the providers working within a transforming health system. This is the largest set of investments, with a proposed budget of $7.1 million.
    ii. *Patient engagement:* In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest $2.2 million to provide patients access to tools that increase their involvement in their own care.
    iii. *Access to increased data capacity and expertise:* Rhode Island's healthcare community agrees that we are not using data as effectively as we could be – and that we lack both standardized data collection, and training of staff responsible for collecting, inputting, and analyzing the data. SIM will invest $5.3 million in this data capability pillar to help tie data to quality and outcome improvements.

3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.

4. Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved integrated physical and behavioral health for the state's residents.

5. A Multi-Sector/Multi-Agency Approach. One of the main strategies of Rhode Island's SIM project is to reach a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This will allow us to build on current achievements, expand the reach of these initiatives, avoid duplication of funding, and, we expect, save money.

By the end of the grant period, we aim to produce marked improvements in health care quality, affordability, and population health. Indicators of success will be transformed provider practices poised to succeed under value-based payment arrangements, a capacity to use data effectively and creatively to make change and monitor system performance, empowered patients (and families) who act as agents in their care, and a health care system that operates *as a system* and delivers whole person care centered around the goals and needs of each patient.

Background: SIM Operational Plan

The fundamentals of the Rhode Island SIM Test Grant are based on a vibrant body of healthcare reform work over the past decade that has been described and analyzed by healthcare leaders and stakeholders participating in a variety of initiatives, most notably the Rhode Island State Healthcare Innovation Plan (SHIP) process led by then Lt. Governor Elizabeth Roberts.

The Centers for Medicare and Medicaid Services (CMS) awarded Rhode Island $1,631,042 to participate in the SHIP process, which was intended to "improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries–and for all residents of participating states."

By early 2014, Rhode Island had completed the work of round one through an extensive stakeholder engagement process led by Lt. Governor Roberts, with technical assistance from The Advisory Board. The result was the *Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost*. In July 2014, Rhode Island applied for the second round of SIM awards in order to test its model design. As part of round two, 32 awardees received $660 million. Rhode Island has received a $20 million award to test its healthcare payment and service delivery reform model using this Operational Plan as the guiding document. The Plan includes an in-depth description of our SIM components fulfilling all of the CMS requirements, and a significant Integrated Population Health Plan that looks equally at physical and behavioral health.

Historical Context

Aside from the SHIP, several other bodies of work have contributed to the landscape in which the Rhode Island SIM Test Grant Operational Plan is being built. Initiatives such as the Statewide Healthcare Inventory and the Truven Behavioral Health Report have been instrumental in quantifying the gaps and needs within Rhode Island's healthcare system. Furthermore, the following examples of initiatives that have preceded SIM or happened alongside SIM have contributed to the sense of urgency for healthcare transformation in Rhode Island:

- The Rhode Island Health Care Planning and Accountability Advisory Council, formed by the Rhode Island General Assembly;
- The Rhode Island Healthcare Reform Commission, created by Governor Lincoln Chafee and chaired by then Lt. Governor Elizabeth Roberts;
- Health Stakeholders Convention led by US Senator Sheldon Whitehouse and Rhode Island Foundation President and Chief Executive Officer Neil Steinberg; and
- Working Group for Healthcare Innovation, convened by Governor Gina Raimondo.

As Rhode Island noted in our SHIP document, the World Health Organization's definition of health states, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Rhode Island has the building blocks for a healthy society, including world-class healthcare providers; top medical, nursing, and social work schools; an environment with places to walk and play; a growing community committed to healthy, local food sources; and state leadership that understands how to leverage these building blocks to improve our population health. However, we also face difficult roadblocks to our population health, such as:

- Unacceptable levels of health risks, including lead in our housing stock;

- High opioid addiction rates;
- Rising numbers of children facing behavioral health challenges; and
- Intractable numbers of people with preventable chronic diseases.

Even with our high quality healthcare providers, most would agree that our "healthcare system" lacks coordination among providers, rewards providers with little or no regard to the quality of the care given, and struggles to meet the needs of all patients in terms of access. Now is the time to make the changes we need. Our SHIP plan paved the way with a call for real reforms, noting that "given the current environment of change in healthcare, the window of opportunity to change the healthcare system is open wider than it has been in a generation." The implementation of federal reforms, changes in the market, aging of the population, and breakdown of the old business model have created an impetus for change. This impetus is further supported by the recent increase in the number of Rhode Islanders covered by health insurance.

Guiding Principles for our SIM Planning

The Rhode Island SIM Test Grant planning process has been guided by eight principles that together describe the overarching work of our efforts. These principles have been agreed upon by a diverse group of Rhode Island stakeholders from across the state. Our partners draw from state and local government, the private sector, academia, and various community organizations with expertise in both public health and clinical care. These principles guide our Integrated Population Health Plan as well as this overall SIM Operational Plan:

1. ***We begin with a commitment to empowering individuals, families, and communities to improve their own health.***
   Any successful efforts to improve population health must include efforts to activate Rhode Islanders with the skills, knowledge, and motivation they need to live healthy lives. Rhode Islanders deserve access to clear and usable information about how their care is provided, what it costs, and how they are billed. We are also committed to making it easier for local communities to be involved in the development of goals, strategies, and policies that improve conditions impacting their health through effective planning, the use of key regulatory and policy levers, and community engagement. Workforce development is a key tool in these efforts. We aim to empower communities from within by helping residents with existing cultural and linguistic competence receive the training they need to take on new roles such as community health workers, clinicians, and behavioral health specialists.

2. ***We embrace our reliance on multi-sector and multi-agency collaboration.***
   Improving population health and decreasing inequalities in health requires a multi-agency, multi-sector, and public/private partnership approach that includes expanding our current understanding of what creates health and focuses on local, geographically based interventions whenever possible. The success of our SIM grant project will rely on significant collaboration among a range of partners, include those in mental health, substance use, primary care, education, public safety, social service, and faith-based communities. Strategic planning must be well coordinated to fully identify the impact of policies not only on overall population health, but also on health disparities. Such coordination will also help to prevent the duplication of efforts, to highlight gaps in service development, and to identify potential useful data linkages. Rhode Island recognizes that policies related to transportation, housing, education, public safety, and environmental protection will affect the health and well-being of residents as much as any policies specifically related to Rhode Island's public health, medical, and behavioral

health system. This requires a "no wrong door" and "health in all policies" approach where the potential health impact is considered.

3. ***We will improve our ability to collect, share, and use data to drive action.***
Assessment of whole-person health outcomes, risk factors/determinants, interventions, and policy effectiveness requires usable, sustainable, and shared surveillance systems that produce timely measures for action and data. That data is also only truly useful if it is available across institutional or organizational boundaries through accessible and user-friendly health information technology. Our Rhode Island SIM Test Grant Operational Plan and our Integrated Population Health Plan stress the importance of strengthening our data sources and empowering our communities to use those sources effectively to better coordinate care. Rhode Islanders deserve tools to help them make informed decisions about their personal health and the overall health of the state. The Rhode Island SIM Test Grant will use the data we produce and analyze to evaluate our activities on a regular basis and to ensure that we are spending our dollars as effectively as possible.

4. ***We believe in an integrated approach to the physical and behavioral needs of Rhode Islanders.***
Rhode Island is committed to developing and implementing an integrated approach to population health that embraces the whole person and considers the physical and behavioral health needs of our residents. By behavioral health, we include mental health and substance abuse. All recommendations and metrics in the Operational Plan and Integrated Population Health Plan reflect this cohesive approach, which we refer to as "whole person care." For example, although tobacco use, obesity, diabetes, stroke, and heart disease are traditionally considered "physical" diseases, our plans acknowledge and address how these health conditions are intertwined with the behavioral health needs of the state's population. The plans recognize the significant role primary care practitioners play in addressing the relationship between patients' physical and behavioral health needs throughout their lifespan, centering the "whole person care" approach as the hallmark of population health improvement efforts in our project.

5. ***We are transforming our healthcare delivery system by moving away from a fee-for-service payment model to a value-based approach.***
Our plan embraces the evolving role of new models of health care delivery such as patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and accountable care communities (ACCs) to improve population health. The plan also recognizes collaborative care approaches that integrate behavioral healthcare into primary care practices. The new system must be multi-payer and collaborative. Included in our approach is a recognition that physical and behavioral health approaches must transform from disease-focused treatment to care that focuses on prevention and early detection Included in this approach is the integration of evidence-based interventions where appropriate and available. In all these cases, Rhode Island's healthcare delivery system will accept responsibility for managing care and improving the health of populations through established multi-sector and multi-agency partnerships.

6. ***We are committed to recognizing the importance of and addressing the social and environmental determinants of health and health equity.***
Health is created where we live, learn, work, and play. Therefore, Rhode Island's SIM Project focuses not only on improving clinical care, but using the levers of public policy and state leadership to influence the various social, economic, and environmental factors

that affect all Rhode Islanders' health outside of the medical and behavioral healthcare delivery systems precisely where they live or work. These considerations include examining strategies that both promote whole community resiliency and recovery, and reduce inequalities in factors that influence health across the diverse populations in our state. Factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution in the population. To ensure we capture both processes in Rhode Island, our Integrated Population Health Plan examines not just statewide estimates for our specific health focus areas, but also disparities in those health outcomes across Rhode Island communities.

7. ***We value consistent and reliable support for providers embarking upon practice transformation.***
   Rhode Island is committed to empowering physical and behavioral healthcare providers to transform their practices "to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations they serve." Specifically, providing assistance to grow and strengthen the presence of Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs) and Community Behavioral Health Centers of Excellence. This empowerment includes support for changes in approach and infrastructure, as well as opportunities to actively participate in the state's overall efforts to transform our delivery system. Workforce development also plays a role in these efforts, giving providers the skills and additional team members they need to provide comprehensive whole person care.

8. ***We end with a commitment to addressing disparities on many levels.***
   We begin with a focus on the individual consumer or patient, their family, and others in their care network–and we end with this focus too. Fundamentally, efforts in population health improvement attempt to bridge what happens in the healthcare delivery setting in the provider's office, the clinic, or hospital bed to what happens in the places where people live their lives (e.g., home, workplace, school). The activities of our Rhode Island SIM Test Grant and findings within our Integrated Population Health Plan will guide our efforts to improve the health of the entire population of residents, as well as investigate and address why some population groups are healthier than others. This approach requires a focus on the overall distribution of the specific Integrated Population Health Plan priority areas in the state, and the differences between groups to highlight disparities in those health areas.

CMS' $20,000,000 investment in Rhode Island's healthcare system is allowing the SIM Steering Committee and state staff team to bring the SHIP plan to fruition. This Operational Plan describes our system transformation approach, which is made up of several coordinated investments and plans to leverage the state's regulatory levers to implement reform. The Rhode Island SIM Test Grant is committed to maintaining an energetic level of stakeholder engagement in reform that together, will help build a new, more sustainable healthcare system in the state. This system will be based on value-based payments for care rather than on volume, will prioritize equally physical and behavioral health, and will focus on addressing the social and environmental determinants of health to address our vision of the Triple Aim.

Driver Diagram

Table 1: Driver Diagram

Vision
IMPROVE THE HEALTH OF RHODE ISLANDERS Create measureable improvements in Rhode Islander's physical and mental health. Targeted measures include, but are not limited to, rates of diabetes, obesity, tobacco use and depression.

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING Move to a "value-based" health care system that pays health care providers for delivering measureable high quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.	Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies	Using regulatory and purchasing/contracting levers at OHIC and Medicaid, implement rules and conditions that expand value-based payment more broadly across the commercial and Medicaid markets	Continue to implement OHIC's Affordability Standards and Medicaid's Accountable Entities; ensure their alignment and integration with other state and private VBP activities	Percentage of payments made under an APM.	50%	Pg. 43
				Percentage of payments linked to value.	80%	Pg. 43
		Aligning quality measures for healthcare contracting	Create an ongoing governance structure to implement the prioritized measure set	N/A	N/A	Pg. 44
		Enhance and/or create programs to address needs of high utilizers coordinated across payers	Support integrated Community Health Teams	See CHT metrics under aim 2.	See CHT metric targets under aim 2.	Pg. 36
	Increase use of data to drive quality and policy	Maximize the use of HealthFacts RI, Complete the Common Provider Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP.	Maximize the use of HealthFacts RI: Support and maintain the claims data collection process; support advanced reports and analytics; and support the coordination of data validation, release, and analysis	# of publically available reports released from HealthFacts RI per year	6	Pg. 41
				# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year	10	

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING, continued	Increase use of data to drive quality and policy continued	Maximize the use of HealthFacts RI, Complete the Common Provider Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP. continued	Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single "source of truth" record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.	CUM # of state agencies using common provider directory	5	Pg. 42
				CUM # of private sector health care organizations using common provider directory	15	
			Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.	10 or more	Pg. 43
				CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.	10 or more	
		Enhance state agencies' data and analytic infrastructure by modernizing the state's current Human Services Data Warehouse	Modernize the state's current Human Services data Warehouse to create an integrated data ecosystem that uses analytic tools, benchmarks, and visualizations;	N/A	N/A	Pg. 43
			Carry out qualitative and quantitative evaluation of the effect of alternative payment models in use in Rhode Island and the value of more closely aligning the models across payers	N/A	N/A	Pg. 43

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a value-based payment arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of x% of Rhode Island's healthcare workforce.	Maximize & support team-based care	Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care	Create 2 new CHTs; Investigate the need for a more formal CHT training and certification program; Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices;	Number of active SIM-funded CHTs	2	Pg. 36
				Percent of new, SIM-funded CHTs actively seeing patients	100%	
				Number of unique practices utilizing new, SIM-funded CHTs	5-10	
				Number of CHTs participating in the statewide CHT consolidated operations model	4	
				Percentage of completed data reports submitted by consolidated operations team	100%	
				Number of provider trainings delivered about practice transformation and CHT benefits	50	
				Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients	TBD	
				Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)	100% *Note this target is highly aspirational since patients are free to choose whether to receive services or not.*	
				Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare	100%	
				Percentage of patients referred to and seen by applicable CHTs who received an annual influenza vaccination	100%	

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION Continued				Number of Community Health Workers certified through the Rhode Island Certification Board	65	
				Percentage of CHTs employing Certified Community Health Workers	100%	
				Number of patients in provider panels with referral ties to SIM CHTs	TBD	
				Percent of RI residents with access to CHT (SIM funded + Existing)	TBD	
	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access program, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Support the PCMH expansion to 9 pediatrician sites	CUM # of practices participating in the pediatric PCMH program	9	Pg. 38
				CUM # of clinicians participating in the pediatric PCMH program	75	
				CUM # of patients attributed to practices participating in the pediatric PCMH program	30000	
			Provide child psychiatry consultation services to pediatrician practices; Train PCPs to expand their ability to treat some behavioral health needs in their practices	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services	40	
				CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services	200	
				CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services	200	
				CUM # of patients served under the child psychiatry access program	7500	

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
			Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.	CUM # of providers who have been trained in SBIRT	250	Pg. 39
				CUM # of practice sites participating in integrated behavioral health initiative	12	
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION, continued	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access program, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Support CMHCs with practice transformation and to receive data about their patients	CUM # of CMHCs that received provider coaching	8	Pg. 40
				CUM # of CMHCs with real-time ED and inpatient dashboards in use	8	
				CUM # of providers trained to use dashboards at CMHCs	120	
			Assist providers in aggregating data from their Electronic Health Records, to help make reporting and practice transformation easier; Provide training to providers in how to interpret the data to make positive changes within their practices; Pursue making this quality data available to patients.	(2.8) Provide learning sessions for providers on interpreting data from the Healthcare Quality Measurement Reporting and Feedback System and how to use it for quality improvement.	(2.8) At least 2 learning sessions held by 2018, and an additional 4 sessions by 2019.resources (if outside the CMHC).	Pg. 40

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	Ops. Plan Page #
3. EMPOWER PATIENTS TO BETTER ADVOCATE FOR THEMSELVES IN A CHANGING HEALTHCARE ENVIRONMENT AND TO IMPOVE THEIR OWN HEALTH Engage and educate patients to participate more effectively in their own health care in order for them to live healthier lives. Invest in tools (e.g., online applications, patient coaches – appropriate for the patient's demographic profile) to teach patients how to navigate effectively in an increasingly complicated health care system.	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Patient engagement tools or processes	Create or implement existing processes or tools that allow patients more control of their health and healthcare decision-making; Train providers and patients in how to use these tools to maximize their effectiveness	Metrics TBD within 6 months	Targets TBD within 6 months	Pg. 41
			Use Community Health Teams to help implement Patient Empowerment tools	Metrics TBD within 6 months	Targets TBD within 6 months	Pg. 41
		End-of-Life/Advanced Illness Care Initiative outreach, and patient and provider education	Increase the number of Rhode Islanders with Advance Directives through training of providers and patients; Ensure that Rhode Islanders can upload their Advance Directives to Current Care	Metrics TBD within 6 months	Targets TBD within 6 months	Pg. 41

Core Metrics and Accountability Targets

Core Metric Set

For each milestone, or objective, core metrics have been developed to track progress over time and identify implementation barriers related to SIM. The measures are a combination of required items from the Centers for Medicare and Medicaid Services (CMS) and those identified as important by Rhode Island. These measures will be updated quarterly or annually as part of performance monitoring.

Metrics, Baselines, and Accountability Targets

Baseline data for each metric was obtained from a variety of data sources. Below is a table that contains each metric, baseline, and target. Any relevant notes related to the data (e.g., lag times for reporting) are also noted.

Due to uncertainties around project scope until actual procurements take place, some of the metrics and targets that are listed may require revision. We have made our best attempt to specify meaningful metrics and aggressive targets. We will notify CMMI promptly should metrics need revision and seek approval to change them. Any baselines or targets listed as TBD will be populated within 3 -6 months from the approval date of this operational plan.

Not listed in Table 2 are plans to report on a set of clinical quality measures. Once we have built the Quality Measurement, Reporting, and Feedback System we may publically report aggregate performance on the core quality measures discussed under the quality measure alignment section.

Please note: Some metrics are assessed over populations specific to the SIM programs, and others are assessed over the entire state population.

More detailed descriptions of the core metrics and annual targets are provided in Appendix 1.

Table 2: Metrics, Baselines, and Targets

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Model Performance	Insured Claims Trend PMPY	1.8% (2011-12)	<=3.5%	3.5% represents the long-term average rate of growth in gross state product. 6-9 month lag for claims run out.	Model Performance
	Plan All Cause Readmissions	TBD within 3 months	TBD within 3 months	RI plans to use the 3M methodology but will investigate alternatives such as NQF# 1768	
	ED Visits per 1000 Members	TBD within 3 months	TBD within 3 months		
Move to a value-based health care system that pays healthcare providers for delivering measurable high quality care, rather than paying for volume.	Percentage of payments made under an APM.	2014: 24% Commercial 2014: 0% Medicaid	50%	Commercial refers to commercial fully insured. Medicaid payments reflect those made by Managed Care Organizations. Reporting will be annual or semi-annual. 6 month lag for claims run out and settlements.	Payer Participation
Move to a value-based health care system that pays healthcare providers for delivering measurable high quality care, rather than paying for volume.	Percentage of payments linked to value.	2014: ≈50% Commercial 2014: 0% Medicaid	80%	Commercial refers to commercial fully insured. Medicaid payments reflect those made by Managed Care Organizations. Reporting will be annual or semi-annual. 6 month lag for claims run out and settlements.	Payer Participation
Support Integrated Community Health Teams & Investigate the need for a more formal CHW training and certification program; Provide training to providers (PCPs,	Number of active SIM-funded CHTs	0	2	Targets represent goals by the end of the project. Some metrics and targets may be revised after procurement. Any target that is TBD greatly depends on procurement.	Model Participation
	Percent of new, SIM-funded CHTs actively seeing patients in Rhode Island	0	100%		
	Number of unique practices utilizing new, SIM-funded CHTs	0	5-10		

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
CMHCs and hospitals) to better incorporate CHTs into their practices.	Number of CHTs participating in the statewide CHT consolidated operations model	0	4		
	Percentage of completed data reports submitted by consolidated operations team	0	100%		
	Number of provider trainings delivered about practice transformation and CHT benefits	0	50		
	Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients	0	TBD		
	Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)	0	100% *Note this target is highly aspirational since patients are free to choose whether to receive services or not.*		
	Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare	0	100%		
	Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination	0	100%		
	Number of Community Health Workers certified through the Rhode Island Certification Board	0	65		

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
	Percentage of CHTs employing Certified Community Health Workers	0	100%		
	Number of patients in provider panels with referral ties to SIM CHTs	0	TBD		
	Percent of RI residents with access to CHT (SIM funded + Existing)	8% *(85,300 patients are in practice panels with ties to existing CHTs)*	TBD		
Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single "source of truth" record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.	CUM # of state agencies using common provider directory	0	5		Model Participation
	CUM # of private sector health care organizations using common provider directory	0	15		
Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.	0	>10		Model Participation
	CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.	0	>10		

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Increase use of data to drive quality and policy through HealthFacts RI (Rhode Island's All Payer Claims Database)	# of publically available reports released from HealthFacts RI per year	0	6	Metrics reflect public reporting capability and data requests.	Other
	# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year	0	10		
Support expansion of PCMH programs to pediatric practices sites.	CUM # of practices participating in the pediatric PCMH program	0	9	PCMH began 1/1/2016.	Model Participation
	CUM # of clinicians participating in the pediatric PCMH program	0	75		
	CUM # of patients attributed to practices participating in the pediatric PCMH program	0	30000		
Provide child psychiatry consultation services to pediatric practices; Train PCPs to expand their ability to treat some behavioral health needs in their practices	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services	0	40	Targets may be revised after procurement.	Model Participation
	CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services	0	200		
	CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services	0	200		
	CUM # of patients served under the child psychiatry access program	0	7500		

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.	CUM # of providers who have been trained in SBIRT	0	250		Model Participation
	CUM # of practice sites participating in integrated behavioral health initiative	0	12		
Support CMHCs with practice transformation and to receive data about their patients;	CUM # of CMHCs that received provider coaching	0	8		Model Participation
	CUM # of CMHCs with real-time ED and inpatient dashboards in use	0	8		
	CUM # of providers trained to use dashboards at CMHCs	0	120		

Master Timeline

Table 3: Master Timeline

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Planning & Governance															
Overall Program Management and Strategic Planning	Marti Rosenberg														
Lead the SIM core team															Weekly meetings
Oversee vendors															Regular weekly supervision
Lead monthly Steering Committee meetings															Monthly Steering Committee (SC) meetings, with preparatory meetings with Secretary Roberts, Commissioner Hittner, and Chairman Giancola 1 week before the SC.
Creation of the SIM Operational Plan															Next draft by 5/31/2016, final approval by CMS by 6/30/2016
Integrated Pop Health Plan (IPHP) (Population Health & Behavioral Health)	James Rajotte/ Ann Detrick														
Complete for integration into Operational Plan															Next draft by 5/31/2016, final approval by CMS by 6/30/2016 Vet Population Health Assessment Measures with RI SIM Steering Committee by end of Q1, 2016.
Continued development of IPHP, including expansion of IPHP to include additional population health focus areas.															Our consultants will be working on the Population Health Plan through the summer, to continue to hone the components and align them with our legislatively required state health plan. Goals, existing initiatives, and strategic frameworks from EOHHS entities, other government agencies
Ongoing oversight of SIM IPHP implementation and data monitoring															The integration of the Population Health Plan will be overseen by a combination of the Interagency team, the PHP workgroup, and the Steering Committee. The interagency team will have this on their agenda bi-weekly throughout the SIM process, the Steering Committee has the opportunity to check in on the progress monthly (but may address it as necessary), and the Workgroup is likely to meet quarterly throughout the process. In addition, RIDOH and BHDDH staff will be overseeing the work of the vendors

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
															addressing population health, and can flag key issues as they arise.
Alignment of IPHP into additional RIDOH statutory, accreditation, and improvement planning requirements															RIDOH staff will take the lead on this, beginning in October, with continued alignment with SIM.
Host IPHP Roadshow and Public Forums															Bring IPHP to all counties of RI for local level feedback, confirmation of identified health issues, and information on additional areas for alignment within SIM and the State Health Plan.
Reporting	Marti Rosenberg														
Quarterly Reports															Quarterly Submissions - Feb, May, Aug, Nov
Annual Reports															
Rhode Island Health System Transformation															
Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing, regulatory levers and SIM investments in workforce, health information technology, and data capacity.															These are the main transformation activities of the SIM grant process. The regulatory levers currently exist at OHIC and Medicaid, and will be implemented and refined throughout the SIM grant time period.
Investing in Rhode Island's Healthcare Workforce and Practice Transformation															
Practice Transformation Activities															
Community Health Teams (CHTs)	Sarah Nguyen/James Rajotte, with Hannah Hakim														
Participate in Community CHT Workgroup															This community Workgroup that SIM participates in meets monthly. SIM staff have input into the agenda, and can raise any issue that

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
															we want to discuss with leaders of the state's existing Community Health Teams (CHTs).
Procurement & Contracting															We aim to submit an RFP to Rhode Island Purchasing in July to procure two new CHTs. We expect to be able to sign a contract with a vendor by December 31, 2016.This will include procurement of a Consolidated Operations Model for new and potentially existing teams. Yearly enhancements for current and new teams, (e.g., aligned tools, assessments, provider training) will also be procured as we continue to evaluate the Teams' needs arise and take recommendations from Team leaders.
Implementation															Implementation will begin with the creation of the CHT contract, and will continue through the end of our SIM grant period. Oversight will be led by regularly through RIDOH, EOHHS, and OHIC staff members, overseen by the Interagency Team and the Steering Committee.
Progress Monitoring and Evaluation															Progress monitoring of implementation once procurement is complete will be ongoing using reporting requirements and data gathering per the scopes of work. We will conduct Intense return on investment evaluation and we will produce reports on the SIM CHTs during Year 4, in consultation with the SIM Evaluation Vendor(s).
Child Psychiatry Access Program	Ann Detrick														
Procurement & Contracting															The procurement for the Child Psychiatry Access Program is likely to be a single source process, not an RFP. The process will begin in June 2016 and we expect it can be completed by August 31, 2016.
Implementation															By August 31, 2016: Contract in place and program starts. By September 30, 2016: 1) Completion of rolling process of outreach, enrollment, orientation and training of pediatricians and 2) Full program operations in place.
PCMH Kids	Sarah Nguyen														

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Procurement & Contracting															The procurement for the PCMH Kids program will be a single source process to CTC RI, not an RFP. The process will begin and July 2016 and we expect it can be completed by August 31, 2016
Implementation															The PCMH Kids project through CTC has already begun, so this funding will be immediately integrated into the ongoing program.
Behavioral Health Transformation	Ann Detrick														
Integrated Behavioral Health															
Procurement & Contracting															The procurement for the Integrated Behavioral Health program will be a single source process to CTC RI, not an RFP. The process will begin in June 2016 and we expect it can be completed by August 31, 2016.
Implementation															By August 31, 2016: Contract in place. By September 30, 2016: The Integrated Behavioral Health program through CTC has already begun, so this funding will be immediately integrated into the ongoing program. Orientation of primary care practices will be completed by September 30, 2016, and the program and evaluation process begins.
SBIRT															Five-Year Federal Grant awarded May 20,1016
Procurement & Contracting															Start Date TBD according to Federal timeline. By End of Qtr 2 (December 31, 2016): Completion of start-up including hiring Program Manager, Evaluator, and Educators/Navigators; Identify providers' EHR and IT capacities. By End of Qtr 3 (March 31, 2017): Contracts developed with health care providers and program initiated.
Implementation															
CMHC Provider Coaching															

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Procurement & Contracting															We aim to submit an RFP to Rhode Island Purchasing in July 2016 to procure the Community Mental Health Center Providence Coaching program. We expect to be able to sign a contract with a vendor by December 31, 2016.
Implementation															January 1, 2017: Contract in place and program started. February 15, 2017: Phase-in completed with full implementation of coaching program. The program will begin with intensive coaching over the first two years, and then regular check-ins in the third year.
Care Management Dashboards															
Procurement & Contracting															The procurement for the Care Management Dashboards will be a single source process to RIQI, not an RFP. The process will begin and June 2016 and completed by August 31, 2016.
Implementation															Build complete by December 31, 2016.
Operational															Please note: Ongoing operations not supported by SIM
Healthcare Quality, Measurement Reporting & Feedback System	Melissa Lauer														
Convene meetings of SIM Technology Reporting Workgroup															Monthly meetings will start to cover governance questions in Fall 2016
Procurement & Contracting															We aim to submit an RFP to Rhode Island Purchasing in July to procure the Healthcare Quality, Measurement Reporting and Feedback System. We expect to be able to sign a contract with a vendor by December 31, 2016.
Implementation															January 1, 2017: Contract in place and vendor begins works on software build. July 1, 2017: First pilot in production and initial training of pilot practices with the first set of measures in progress. January 1, 2018:

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
															Additional practices brought on and additional measures developed. QCDR certification in progress.
Provider Directory Integration															July 1, 2017: Provider Directory integration started.
Operational															System operational with continued onboarding and training as part of normal operations.
Patient Engagement															
Patient Engagement Tools - Details TBD	Ann Detrick/ Melissa Lauer														
Convene meetings of SIM Patient Engagement Workgroup															Monthly meetings
Procurement & Contracting															We aim to submit an RFP to Rhode Island Purchasing in August to procure the Patient Engagement activities. We want to wait until some of the other SIM project are procured, so that we have more clarify about what patient engagement activities will augment their success. We expect to be able to sign a contract with a vendor by June 30, 2017.
Project Implementation															
End-of-Life/Advanced Illness Care Initiative	Ann Detrick/ Melissa Lauer														
Procurement & Contracting															The procurement for the End-of-Life program a single source process, not an RFP. The process will begin and July 2016 and completed by September 30, 2016
Project Implementation															Implementation of the training and patient engagement process can begin by October 1, 2016.
Increasing Data Capability and Expertise															
Statewide Common Provider Directory	Melissa Lauer														Procured
Convene Provider Directory Advisory Committee (PDAC)															
Implementation															

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Phase 1 Data Extracts Available															Data extracts will be available to customers in August 2016
Phase 2 Consumer Portal Available															Consumer portal launch by July 2017
Phase 3 Provider Portal Available															Provider Portal launch by July 2018
Operational															All planned components of the Provider Directory complete by August 2018
HealthFacts RI (APCD)	Melissa Lauer														Procured
Project Implementation															APCD Implementation already in progress at beginning of grant period. SIM supports continuing implementation
Interagency Staff Workgroup Meets															Weekly
State Analysts Meet															Weekly
Data Release Review Board Meets															Monthly
Vendor Re-procurement															
Provider Directory Integration															Completed by mid-2017
Operational															Operational activities involve continued acceptance of files, and data release.
State Agency Data and Analytics Infrastructure	Kim Paull														
Procurement															We aim to submit an RFP to Rhode Island Purchasing in September to procure the State Agency Data Ecosystem. We expect to be able to sign a contract with a vendor by March 31, 2017.
Implementation															Vendor will begin implementation by April 2017, involving incorporating priority databases and training state staff across multiple agencies. Necessary data sharing agreements will be put in place between agencies.
Provider Directory Integration															Data linked to Provider Directory by March 31, 2018
HealthFacts RI Integration															HealthFacts RI data incorporated by August 31, 2018.

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Operational (With continued integrations with additional databases)															Continued data integration will be part of expected operations.
Other Transformation Activities															
Measure Alignment	Cory King / James Rajotte														
Implementation of chosen measures															Implementation will occur through a process led by OHIC, beginning January 1, 2016.
Ongoing governance of measure alignment through the Measure Alignment Workgroup and Bailit Health Purchasing															These will be monthly meetings led by Bailit Health purchasing. They are a sub-contractor under UMass' Medical School.
Annual measure review, using the Measure Alignment Workgroup															The state will hold quarterly meetings of the workgroup, which will act as the governance body for the implementation.
Measure Development and Integration															Work with Measure Alignment Workgroup, identified state agencies, and Data and Analytics staff at EOHHS to identify ways to capture new data for population health planning (e.g., socio-demographics) within existing systems. Continue to reduce administrative burden by standardizing measure sets and collection, where applicable (e.g., aligning IPHP measures to clinical quality measures as development continues). This work will also feed into SIM evaluation.
Regulatory Levers	Cory King/ James Rajotte														
Review of available regulatory levers, using State Interagency Team and other Workgroups															Where applicable, expand lever identification to not only healthcare transformation but policy related to the social and environmental determinants of health to address our SIM Theory of Change.
Application of existing levers and addition of new levers, as necessary or appropriate															Ongoing implementation and development, as needed. Consideration of a Regulatory Workgroup will be based upon need and identified challenges for SIM implementation.

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Integration & Alignment															
Pursing a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities.															Rhode Island has many exciting initiatives and opportunities within its arsenal for both transformation and population health planning. Rhode Island views SIM as a vehicle to create innovative and sustainable expansion of the necessary community-clinical linkages that explore addressing the social and environmental determinants of health. This is an ongoing part of SIM, taking place every day throughout our Steering Committee, Interagency Team, and staff team work.
Additional Healthcare Workforce Development															
Convene meetings of SIM's Healthcare Workforce Transformation Workgroup to study additional workforce development needs															We are planning monthly meetings to begin this work, starting in late July, 2016.
Carry out Workforce Assessment and plan additional implementation activities for the rest of SIM															
Evaluation															
Federal Evaluation	Marti Rosenberg														
Participating in regular communications with national evaluation team															Monthly meetings
Assistance with site visits															
Rhode Island-based evaluation, including Learning Collaborative on Payment Reform Effectiveness	James Rajotte														
Procurement & Contracting															
Project Implementation															

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Internal Tracking of Measures	Cory King, with all SIM Staff														
Project Implementation															Rhode Island is developing four tiers of measures for SIM: Core Metrics and Model Performance (Y1, Q4); Procurement Monitoring Objectives and Activity Indicators (Y2, Q2); Evaluation Measures (Y2-Y4); and IPHP Assessment Measures (Y1, Q4). For more information on IPHP Measures, see the "IPHP Measure and Metric Alignment Process" sub-section.

Please note: Rhode Island is aware that we will be procuring a significant number of projects with a large amount of money, in a relatively short period of time. We have noted some of these challenges in our Risks Mitigation section. Our major strategy for this procurement is to divide up key procurement responsibilities about all of our state staff, share information and align work on the parts of the process that will be the same across activities, seek technical assistance on RFP language and metrics from national support organizations that will not be bidding on the projects, and work closely with our purchasing department so that we follow all state laws and regulations and avoid mistakes.

Budget Summary Table

Table 4: Budget Table

SIM Component	Projected Expenditure	Expected Spending 7/1/2016 – 6/30/2017	Expected Carryover from 2015-2016 Spending	Goal/ Primary Driver	Metric
Rhode Island Health System Transformation	In-kind from OHIC and Medicaid	In-kind – Staff	In-kind – Staff	Create measureable improvements in Rhode Islander's physical and mental health.	Percentage of payments made under an APM.
					Percentage of payments linked to value.
Community Health Teams	$2,000,000 – Training/Capacity Building - $250,000 Oversight and Data and Two Teams (for 3 years): $1.750,000	$333,333	$333,333	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Number of active SIM-funded CHTs
					Percent of new, SIM-funded CHTs actively seeing patients
					Number of unique practices utilizing new, SIM-funded CHTs
					Number of CHTs participating in the statewide CHT consolidated operations model
					Percentage of completed data reports submitted by consolidated operations team
					Number of provider trainings delivered about practice transformation and CHT benefits
					Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients
					Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)
					Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare

SIM Component	Projected Expenditure	Expected Spending 7/1/2016 – 6/30/2017	Expected Carryover from 2015-2016 Spending	Goal/ Primary Driver	Metric
					Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination
					Number of Community Health Workers certified through the Rhode Island Certification Board
					Percentage of CHTs employing Certified Community Health Workers
					Number of patients in provider panels with referral ties to SIM CHTs
					Percent of RI residents with access to CHT (SIM funded + Existing)
Child Psychiatry Access Program	$650,000 - $216,000/yr for 3 years for psychiatrist phone consultation and face-to-face contact for pediatric practices	$216,667	$100,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services
					CUM # of patients served under the child psychiatry access program
PCMH Kids	$500,000 – 166,000 a year for 3 years, for Practice Support Specialists, CAHPS pediatric survey, Quality Measurement and	$166,667	$50,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practices participating in the pediatric PCMH program
					CUM # of clinicians participating in the pediatric PCMH program

SIM Component	Projected Expenditure	Expected Spending 7/1/2016 – 6/30/2017	Expected Carryover from 2015-2016 Spending	Goal/ Primary Driver	Metric
	Reporting, and data analysis				CUM # of patients attributed to practices participating in the pediatric PCMH program
Behavioral Health Transformation: *SBIRT*	$480,000 for Training of SBIRT providers	$160,000	$100,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of providers who have been trained in SBIRT
Behavioral Health Transformation: *Integrated Behavioral Health*	$370,000 $123,000 year/for 3 years for a Behavioral Health Practice Facilitator, Data Collection and Analytics, and Training Webinars.	$185,000	$185,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practice sites participating in integrated behavioral health initiative
Behavioral Health Transformation: *Care Management Dashboards*	$150,000 (15 Dashboards @ $10,000 each)	$150,000	$0	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs with real-time ED and inpatient dashboards in use CUM # of providers trained to use dashboards at CMHCs
Behavioral Health Transformation: *Practice Coaching at Community Mental Health Centers*	$1,200,000 – For 2 to 4 practice transformation specialists onsite over three years, to work with 8 Community Mental Health Center staff teams	$200,000	$220,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs that received provider coaching
Healthcare Quality, Reporting, Measurement and Technology	$1,750,000	$100,992	$300,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.

SIM Component	Projected Expenditure	Expected Spending 7/1/2016 – 6/30/2017	Expected Carryover from 2015-2016 Spending	Goal/ Primary Driver	Metric
Feedback System					CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.
Patient Engagement & End-of-Life/Advanced Illness Care Initiative	$2,200,000 $500,000 – End of Life Training for PCPs; $1,700,000 for Patient Engagement activities, TBD	$160,000	$100,000	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Metric(s) in development.
HealthFacts RI (Rhode Island's All-Payer Claims Database)	$2,039,673	$1,102,336	$82,798	Increase use of data to drive quality and policy	# of publically available reports released from HealthFacts RI per year
					# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year
Statewide Common Provider Directory	$1,500,000	$680,900	$310,113	Increase use of data to drive quality and policy	CUM # of state agencies using common provider directory
					CUM # of private sector health care organizations using common provider directory
Integrated Health and Human Services Data Ecosystem	$1,800,000 –For staffing (a Database Administrator, Database Architect, and an ETL or Data Modeler) and a vendor to build the Data Ecosystem	$250,000	$300,000	Increase use of data to drive quality and policy	N/A
Measure Alignment	Included in the Project Management line item (sub-contractor to Project Management team)	In-kind – Staff	Reflected in staff line below	Create measureable improvements in Rhode Islander's physical and mental health.	N/A

SIM Component	Projected Expenditure	Expected Spending 7/1/2016 – 6/30/2017	Expected Carryover from 2015-2016 Spending	Goal/ Primary Driver	Metric
Leveraging Regulatory Authority	In-kind from all SIM participating state agencies	In-kind – Staff	Reflected in staff line below	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Integration & Alignment Project	In-kind from SIM and agency staff	In-kind -- Staff	Reflected in staff line below	Create measureable improvements in Rhode Islander's physical and mental health.	TBD within 6 months
Workforce Development	In-kind from EOHHS	In-kind – Staff	Reflected in staff line below	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	TBD within 6 months
SIM Project Director and Staffing Across Five Partner Agencies	$3,000,000 6 staff members, fringe, benefits for 3 years	$908,344	$0	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Project Management Vendor	$1,600,000 – $736,939 over 2 years for Program Management; $653,458 for subcontractors to write Integrated Population Health Plan and support Measure Alignment	$401,917	$443,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Evaluation	$700,000 – For a mixed method formative and summative evaluation	$150,000	$0	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Other Expenses	$60,000 – Including travel, audit, and other expenses	$20,000	$0	N/A	N/A
Totals		$5,186,156	$2,524,244		

B. Detailed SIM Operational Plan

This section provides detailed information on the specific operational components of Rhode Island SIM. The information provided covers the following three areas: Narrative Summary of Components, SIM Component Summary Table, and Risk Assessment and Mitigation Strategy.

Narrative Summary of SIM Components

Rhode Island SIM Components

The focus areas of the Rhode Island State Innovation Model (SIM) Test Grant reflected in the SIM Transformation Wheel are the foundational components for this funding investment. Given the overarching aims of SIM, Rhode Island's values, and the current landscape, the Steering Committee has committed to the following components aimed at overall health system change. The components described below and summarized in the SIM Component Summary Table are as follows:

- *Planning and Governance;*
- *Investments in Rhode Island's Healthcare Workforce and Practice Transformation;*
- *Patient Engagement;*
- *Data Capability;*
- *Regulatory Levers; and*
- *Evaluation.*

Planning and Governance

Rhode Island SIM's governance and decision-making authority is shared among a coordinated group of people and agencies, managed by SIM project Director Marti Rosenberg whose office sits at the Office of the Health Insurance Commissioner. Ms. Rosenberg reports to both Commissioner Kathleen C Hittner, and EOHHS Secretary Elizabeth H. Roberts, and leads a team of individuals hired with SIM dollars and placed at member agencies. Ms. Rosenberg also leads the SIM Interagency Planning Team that includes representatives from all SIM participating state departments, plus our Steering Committee Chair, Lou Giancola. This team is responsible for the strategic implementation of the project.

The SIM Steering Committee is the public/private governing body for Rhode Island's SIM project and is comprised of community stakeholders representing health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations. The committee has approved four workgroups (Integrated Population Health Plan, Measure Alignment, Patient Engagement, and Technology Reporting) to obtain subject-matter expertise, stakeholder and community in-put, and implementation recommendations for SIM's transformation efforts. To avoid duplicating community efforts, SIM also obtains valuable input into our work with Community Health Teams and Provider Practice Transformation by participating with two existing community groups.

Ms. Rosenberg also oversees the work of UMass Medical School (UMASS), the SIM Project Management Vendor. UMASS came on board in January 2016 to manage related project management activities including support for stakeholder management, project meetings, data collection, risk management, communications, sub-contractor management, and work plan management. UMASS has also subcontracted with the Technical Assistance Collaborative (TAC) and the Providence Plan (Prov Plan) to provide expertise in behavioral health and physical health, respectively, and write the Integrated Population Health Plan.

System Transformation

Rhode Island has been committed to significant system transformation for years. Rhode Island was an early supporter of primary care practice transformation, building a multi-payer patient centered medical home collaborative in 2008, which now comprises 72 practice sites and serves nearly one-third of the state's population. Building on a solid base of transformed primary care, newly forming accountable care organizations, and initial steps toward value-based payment in the commercial market, our primary strategy is to scale value-based payment statewide by setting regulatory targets for insurers to expand value-based payment models in Medicaid and commercial insurance.

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole.

Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value. In order to achieve our system transformation goal, we are focusing SIM dollars on delivery system transformation with investments in workforce, health information technology, and data capacity, as described below. We also include significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. As we note throughout this document, in Rhode Island, healthcare delivery system transformation is a public-private partnership.

Rhode Island is poised to significantly advance the use of value-based payments and APMs through the implementation period of the SIM grant through regulatory and purchasing activity of both Medicaid and OHIC. In year two, Medicaid will develop certification standards for Medicaid Alternative Entities (AEs), and our Medicaid Managed Care Organizations (MCOs) will contract with them on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state. AEs must also focus on the social determinants of health among their attributed populations. The AE contracting mechanism will be one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018. Managed care procurement, contracting, and Accountable Entity accreditation are three crucial purchasing and regulatory levers that will drive achievement of Rhode Island's payment reform targets.

OHIC will track commercial insurer compliance with their annual APM targets on a semi-annual basis. In addition to semi-annual reporting of APM use, OHIC will require each insurer to develop plans for engagement of specialists in VBP arrangements, including the development of APMs for high volume specialties and specialty care practices. These requirements build on extant rules that obligated insurers to have quality improvement programs with hospitals and tie hospital fee increases to quality performance.

Engagement of payers and providers around payment reform is important for our success. During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation. With an eye toward process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

Besides carrying out system transformation activities aimed at improving quality and lowering the cost curve, the state also aims to help prepare our provider community for the new Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act (MACRA). To ensure that Rhode Island understands the implications of QPP, Rhode Island will embed these discussions in existing stakeholder processes, with training for providers if necessary. The Health Insurance Commissioner will put alignment with QPP on the agenda of her Alternative Payment Methodology Advisory Committee in the fall of 2016. **We aim to leverage our SIM investments and regulatory and purchasing initiatives to prepare providers in Rhode Island for the QPP.** We are also currently pursuing conversations between Medicaid and the commercial health plans around participation in CPC+, which feeds into CMS's draft QPP rule.

Investing in Rhode Island's Healthcare Workforce and Practice Transformation

Community Health Teams (CHTs):

Community health teams are a critical component of Rhode Island's SIM plan. CHTs have the potential to facilitate coordinate care, using dashboards and other tools and integrate care, attending to the whole person (i.e., both physical and behavioral health needs). The SIM Steering Committee approved the following plan, which reflects conversations that have happened in the Community Health Team Workgroup meetings or other forums.

CHTs currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs serve three critical functions:

- Improving population health by addressing social, behavioral, and environmental needs;
- Supporting providers in transitioning to value-based systems of care; and
- Transforming primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures.

CHT Composition and Objectives

All CHTs employ community health workers (CHWs) who are non-licensed generalists serving as peer navigators, care coordinators, or resource specialists. Many teams also include a licensed behavioral health provider and nurse care manager who are considered community-based licensed health professionals (CBLHPs). Some CHTs also have other CBLHPs, such as licensed professionals in pharmacy or nutrition, as well as healthcare professionals serving as clinical educators.

CHTs also serve as an educator and resource to healthcare professionals by teaching healthcare workers about benefits of CHTs in general and patient-centered care, methods for simultaneous treatment of behavioral and physical health needs, and how addressing patients' social needs will aid in **improving** health. CHTs are also specifically focused on the following objectives:

- Through active identification and outreach, assisting individuals and/or families to develop ongoing and consistent relationships with primary care providers and obtain primary care services based on their need;

- Helping staff extend their reach and actively engage patients or families who are at high risk in primary care, home based and community settings;
- Enhancing continuity of care for patients by sharing information through electronic or other means (consistent with the language and literacy needs of the patient or their family);
- Increasing the ability of patients and families to access appropriate community services and resources to address identified social, behavioral, environmental and complex medical needs that have an impact on health

Existing Community Health Teams in Rhode Island
Currently in Rhode Island, there are several different models for CHTs. Operating in various parts of the state, current CHTs each have a slightly different area of focus and model for operation. At this time, CHTs fall into one of the following categories:

- A patient-centered medical home practice extension within a specific geographic area (i.e., CTC);
- A general practice-based team (i.e., Thundermist);
- A payer-based team (i.e., NHP, UHC, Medicaid CHT-RI, and Cedar); or
- An accountable care organization-based team (i.e., currently in development).

The CTC and practice-based teams are accessible to an overall population of approximately 75,000 (attributed) Rhode Islanders and focus interventions on high-risk individuals as defined by health plan and practice criteria. Total population estimates for those who have access to NHP and UHC teams are not currently available, but are focused on high-risk individuals. The Medicaid CHT-RI and Cedar teams are accessible to approximately 14,000 Medicaid beneficiaries. These teams focus interventions on high-cost/rising-risk adults, and children/youth with special healthcare needs, respectively. Cedar is the only current team providing such services to children.

Highest-Risk Individuals
In order to maximize improvements in Rhode Island's population health, address and improve our social and environmental determinants of health, and make progress in eliminating health disparities within our state, CHTs services should be available to all Rhode Islanders who need that level of multi-disciplinary, community-based services to address the factors that impact our health. We have adopted the following criteria to identify individuals considered at "highest-risk" and who are eligible for CHT services:

- Individuals who have three or more known chronic conditions;
- Individuals who have two or more special healthcare needs (i.e., disabilities);
- Individuals who are not accessing primary care regularly;
- Individuals who are unable to access healthcare due to cost; and
- Individuals who have three or more in-patient or emergency department visits within six months.

While exact data that reflects these categories of individuals at "highest-risk" does not currently exist, estimates can be generated. Using data from the Rhode Island Behavioral Risk Factor Surveillance System (RI BRFSS) and HealthFacts RI, the following estimates were calculated:

- A total of 91,444 (11.0%) Rhode Island adults are estimated to have three or more of the following chronic conditions: hypertension, diabetes, CHD, COPD, arthritis, and asthma (RI BRFSS, 2013).
- A total of 76,480 (9.2%) Rhode Island adults have two or more disabilities as defined by five functional components/limitations (RI BRFSS, 2014).
- A total of 164,599 (19.8%) of Rhode Island adults have not visited a doctor for a routine check-up within 12 months (RI BRFSS, 2014).
- A total of 142,153 (17.1%) of Rhode Island adults are unable to access care, meaning see a provider or fill a prescription, due to high costs (RI BRFSS, 2014).
- A total of 16,097 (1.9%) of Rhode Island adults and children within HealthFacts RI have had three or more emergency department visits in a calendar year (HealthFacts RI, 2013; 2014)

Given the current estimated need for those at "highest-risk" and the even larger need for full community access, it is clear that SIM funding is limited in what it can address adequately. The ability of CHTs to adequately serve clients to address social and environmental determinants of health also depends on the existence of adequate social services and supports in the larger community. And thus, the Steering Committee has decided to prioritize a segment of Rhode Island for services. SIM will invest the money allocated for CHTs to meet significant, unmet need as determined by our Integrated Population Health Plan (IPHP) and data from relevant state agencies. SIM's investment will also include data collection from the CHTs we fund, to explore sustainability options and opportunities for expansion over time.

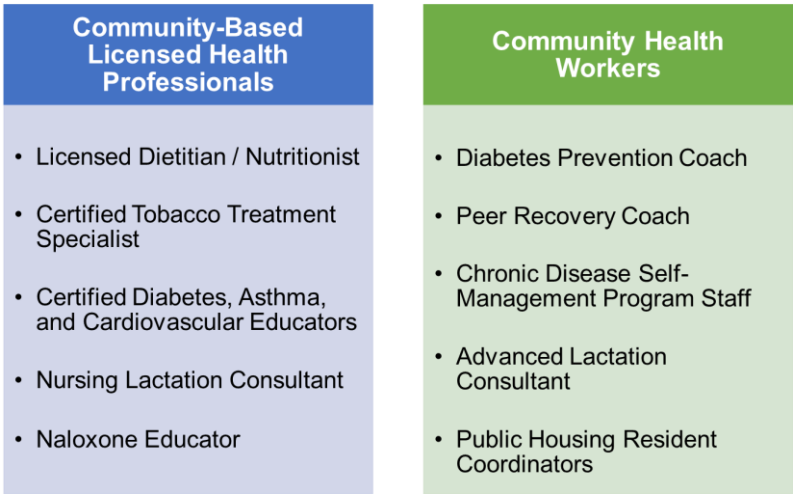
SIM-Funded New Team Creation

SIM is committed to fully-funding two new CHTs with SIM dollars to bring this model's benefits to more people, particularly those located in underserved areas or areas currently not served in the state. Additional emphasis may be placed on geographic locations where there is evidence that there is an increased need for these types of patient-centered services. Minimum requirements for a CHT to receive funding may include the following:

- A new CHT should be multi-disciplinary, payer agnostic, connected with primary care, and consist of at least one CBLHP (preference may be given to those with credentials in behavioral health) and two CHWs;
    - CHWs are non-licensed generalists with a CHW certification and in the absence of certification, those currently acting as peer navigators/care coordinators/resource specialists are considered CHWs
    - CBLHPs are licensed health professionals who will provide clinical education and input into clinical decisions related to care
- The composition of the CHT and the disciplines participating in the teams should reflect the needs and diversity of the community being served;
- The CHT should be accessible to all individuals regardless of insurance (i.e., the CHT funded by SIM should not exclude anyone because of the insurance that they have or because they are uninsured);
- The CHT will participate in the consolidated operations model funded by SIM; and
- The CHT should work directly in the home or the community to address factors that impact people's health, including social, behavioral, and environmental determinants of health.
    - This can include establishing partnerships with existing sources of specialized CBLHPs (e.g., Certified Tobacco Treatment Specialists) and Specialty Community Health Workers (e.g., Diabetes Prevention Coach) or partnering with other

infrastructure (e.g., Health Equity Zones, Community Health Network) to ensure the ability to address the communities' identified needs

Figure 2: Example Specialty Types

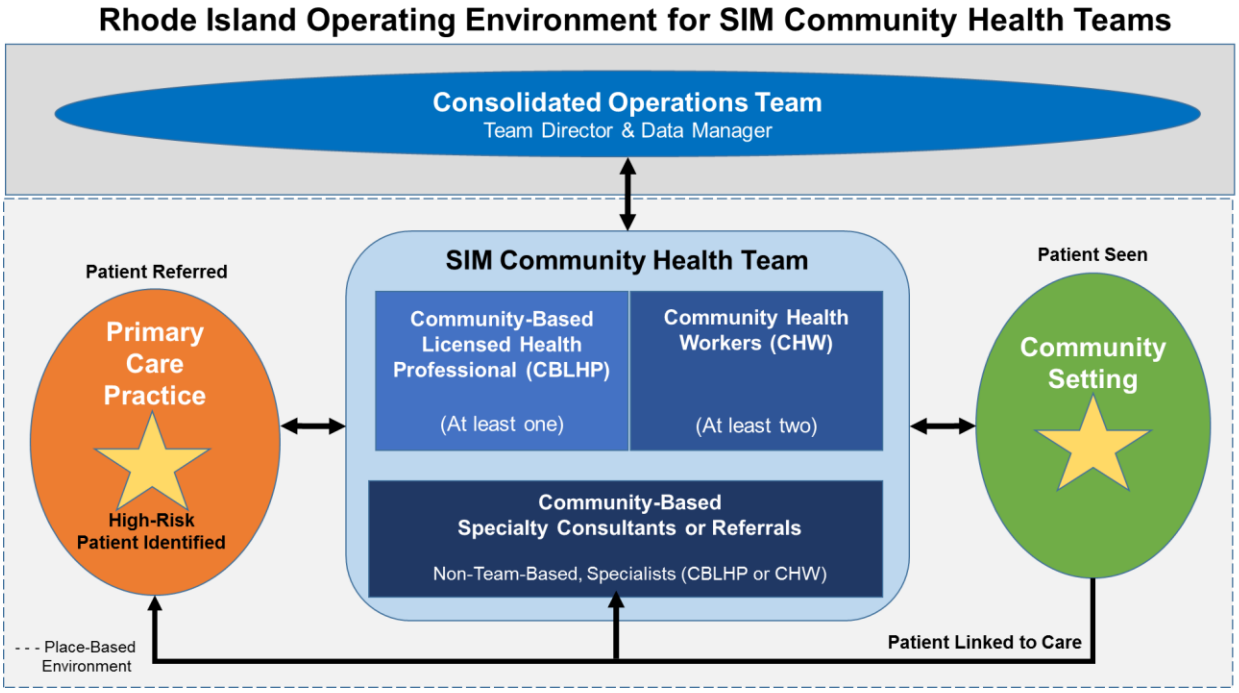


Consolidated Operations for SIM-Funded Teams

At this time, SIM-funded teams will be required to participate in a new model that we call "Consolidated Operations." This model is an attempt to reduce administrative burden by coordinating and consolidating team oversight, data management, and other logistical or operational aspects identified as an overarching need within the funded CHTs. This approach to a centralized yet collaborative provision of overarching infrastructure aims to maximize alignment with state policy and health reform goals, as well as reduce duplication of effort and operational costs. Within this framework, clinical oversight would appropriately remain at the community-level. SIM is also prepared to fund the oversight, data collection, and similar support for all existing multi-payer Community Health Teams, to align the teams' day-to-day work, streamline administrative operations, and save money. At a minimum, consolidated operations may include:

- A CHT team director responsible for oversight of the project and the existing teams;
- A data manager who is responsible for all data collection, health information technology troubleshooting, and reporting;
- A demonstrated ability to obtain additional logistical or administrative support, if needed; and
- Other cost-saving, but necessary resources.
    - For example, should it be determined that ad-hoc access to pharmacy consultation or a public health dental hygienist is essential for the CHT but not the in the full-time CBLHP capacity, a retainer for such services could be maintained by the Consolidated Operations team.

Figure 3: Proposed Conceptual Framework



Existing and New Team Capacity-Building Enhancements
SIM will invest in enhancements for the current and new Community Health Teams with the following:

- Centralized, statewide training and professional development—including promotion of community health worker (CHW) certification and training to be delivered to providers related to CHTs and practice transformation aims;
- Platforms for information sharing, (e.g., care management dashboards and shared plans of care), as well as screening, clinical, or technology tools; and
- Facilitation for the development and evaluation of return on investment studies/findings, proposed financial models, and viable reimbursement strategies for long-term sustainability.

Child Psychiatry Access Program and Patient-Center Medical Homes for Kids:

The pediatric psychiatry referral consultation system will establish a children's mental health consultation team to work with primary care providers to meet the needs of children with mental health care needs. The program is based on the model implemented in Massachusetts, which consist of regionally based teams that provide real-time telephone consultation with child psychiatrists, face-to-face appointments for acute evaluations, and assistance with accessing community-based behavioral health services.

The Access Program is designed to assist pediatricians in their efforts to manage children with behavioral and mental health needs in a way that is preventive and responsive to a patients' immediate need. The funding will create an entity capable of responding to the immediate management needs of children with behavioral health concerns by providing pediatricians with consultation/support and response to emergent situations which will be invaluable for families and children.

We have known about the severe need for psychiatric services for children in Rhode Island for a long time – and there is evidence that this program will work to address the need. One in five (19%) children ages six to 17 has a diagnosable mental health problem, and one in ten has significant functional impairment (Kids Count Factbook, 2015). And a 2014 article in Health Affairs concluded that pediatric primary care providers enrolled in the project reported a dramatic improvement in their ability to meet the psychiatric needs of their patients.

Pediatricians are the front line trusted partner of a parents and children—and the investment of SIM dollars in opportunities for pediatricians to work more directly with families on behavioral health needs will be critical to the well-being of Rhode Island children.

PCMH-Kids builds off of the successes of Care Transformation Collaborative in Rhode Island (CTC-RI), the adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of primary care practices in Rhode Island to children. PCMH Kids' mission is to engage providers, payers, patients, parents, purchasers, and policy makers to develop high quality family and PCMHs for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-driven system improvement. A group of engaged stakeholders and pediatric leaders has been working over the past several years to develop this PCMH-Kids program. A pediatric medical home initiative is an opportunity to standardize and to improve the patient and family centered care already delivered in pediatric offices around our state. PCMH-Kids is convened by the state's Executive Office of Health and Human Services (EOHHS) and Rhode Island Medicaid program, garnering participation from all four major health plans in Rhode Island. The nine selected pilot practices have created a common contract with payers. Practices are receiving supplemental payments and on-site, distance, and collaborative learning and coaching to support practice transformation and quality improvement. SIM funding for PCMH-Kids will include support for the following:

- Practice facilitation and coaching, through a sub-contract;
- Supporting practices with understanding the PCMH-Kids measures and definitions;
- Assisting practices with developing reports to calculate measures in their electronic health record (EHR);
- Assisting practices with developing workflows and processes to regularly produce reports, perform quality assurance and submit data; and
- Assisting practices with analyzing and improving the quality of EHR data.

In addition, evaluation will include the use of the Pediatric Consumer Assessment of Healthcare Providers and Services (CAHPS) PCMH Survey, quality measurement and reporting, and utilization measurement, through a sub-contract with the Rhode Island Quality Institute. Included in this evaluation is methods to determine how patients experience care, how to support practice improvements, how to assist practices in measuring their clinical quality measures, and how to best help practices measure their patients' use of high cost services as a proxy for direct cost and effective care coordination data.

Behavioral Health Transformation:

Integrated Behavioral Health Behavioral health issues are frequently an important area of concern for individuals who visit their primary care practitioners. Behavioral health includes mental health, substance use, and health behaviors. There is ample evidence in medical literature that primary care practices can effectively treat and support many individuals who have mild to moderate behavioral health issues. It is widely acknowledged that, to be successful,

the behavioral health focus must be well-integrated into the primary care practice, not simply co-located. Rhode Island is investing in a behavioral health integration effort begun by the Care Transformation Collaborative (CTC) of Rhode Island, funded by The Rhode Island Foundation and Tufts Health Plan. It that includes the following activities:

- Depression, anxiety and substance use screening;
- Collaboration of behavioral health specialty staff with nursing/physician personnel;
- Effective use of a behavioral health subject-matter expert(s) to support training and development efforts; and
- Knowledge of appropriate measurement and quality assurance activities.

Twelve practices were selected for the Integrated Behavioral Health (IBH) Pilot program, of Rhode Island and all were chosen. Practices submitted written applications using an application package developed by CTC. Applicants answered yes/no or N/A to a series of checklist questions about their readiness to operate an IBH primary care practice, and also answered four essay questions. Included in the application criteria were four prerequisites that each practice had to meet:

Prerequisites:

- Current NCQA Level 2 recognition and continued achievement of CTC program requirements based on stage in developmental contract;
- Team completion and submission of Maine Health Access Tool with application;
- Electronic health record (EHR) system that can produce registry reports based on PHQ-9, GAD, CAGE-AID screening and re-screening results with sample report or screen shot that demonstrates capacity with application;
- Electronic Health Record (EHR) system that can support a shared behavioral health documentation, care plan and billing; and
- A patient panel of 5,000 patients or an MOU with other practices that articulates how the practices would work together to meet the pilot objectives, share resources and financial support.

Applicants were also rated on other criteria including:

1) Electronic Health Record Capacity including ability to bill for behavioral services; registries for depression, anxiety, substance use disorders, high risk patients; standard plus customized reporting capability; designated electronic health record staff/support; ability to provide quarterly screening reports for depression, anxiety and substance use disorders.
2) Behavioral Health Staff including capacity to hire and co-locate or fully integrate behavioral health staff; ability to provide space for behavioral health staff.
3) Reporting Capacity including ability to report on number of unique patients with behavioral health encounters; ability to track referrals to specialty behavioral health programs.

For other practices who are still in the process of planning for behavioral health integration, CTC sponsors Learning Sessions and Webinars to facilitate ongoing improvement of primary care medical homes, including incorporating behavioral health care within primary care practices. There is a monthly IBH Workgroup open to all interested primary care practices where information sharing occurs.

There is a phase-in approach for the 12 practices. The first cohort of six practices began in January 2016. The second cohort of six will begin in November, 2016. Regarding a continuum of

BH-PH integration, all of the practices have licensed behavioral health staff co-located or fully integrated on site at the practices. There is a long list of Phase 1 and Phase 2 requirements. Here is a sample:

IBH Start-Up (Year 1):

All Phase 1 requirements will be implemented within a 6-12 month timeframe.

- Provide baseline report on screening for depression, anxiety, and substance use within one (1) month of award notification;
- Hire behavioral health staff if not already in place with a staffing ratio of 1 FTE for every 5,000 attributed lives with staff ready to see patients within two (2) months of award notification;
- Implement a staffing plan for patients with behavioral health needs to be able to access assessment/treatment with same day to 72 hour access (within one (1) month of start date of IBH clinician or award notification if IBH clinician already hired);
- Establish billing systems that will allow for the billing of behavioral health services and/or establish supervision of behavioral health interns (within three (3) months of start date of IBH clinician or award notification if IBH clinician already hired);
- Produce monthly practice registry reports on screening results (initial and follow-up) within four (4) months of award notification; patients with moderate to high screening scores would be re-screened within six (6) months;
- Produce quarterly reports on screening results within four (4) months of award notification;
- Commit to and host monthly on-site IBH consultation with membership to include practice leadership, physician/clinical champion, nurse care manager, practices (within 30 days of award notification);
- Commit to and participate in quarterly webinar learning events;
- Work to achieve screening targets by twelve (12) months.

IBH Performance Year (Year 2) requirements**:**

- Continue to perform start-p components;
- Monitor/improve patients' treatment response through care coordination review of patient registry scores for depression, anxiety and substance use, chronic care quality measures with submission of a PDSA plan to test change for improvement;
- Implement population health review for patients with high ED usage and behavioral health needs and implement IBH strategies including submission of a PDSA to test change for improvement; and
- Achieve screening targets to be eligible for incentive payment.

SBIRT Training Another priority for behavioral health transformation in Rhode Island is to decrease the use, and impact, of tobacco, alcohol and other drugs. As an example of the need, when compared to national prevalence data, Rhode Island has a higher proportion of adults diagnosed with alcohol abuse or dependence and adults who could benefit from, but are not receiving needed treatment. The toll of tobacco in Rhode Island is high: 1800 adults die each year from cigarette smoking and 500 young people under 18 become new daily smokers each year. Four adult priority populations report higher than average cigarette smoking: adults of low socioeconomic status, African Americans, adults with physical and/or mental disabilities and adults with chronic disease.

In response to this need, the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) has applied for a Collaborative Agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) grant from the Substance Abuse and Mental Health Service Administration (SAMHSA). If funded, this grant will offer, over a five year period, alcohol, drug and tobacco screening to 250,000 Rhode Island adults. Based on the outcome of these screenings, individuals will be referred for brief interventions or treatment, as appropriate. Priority populations for this grant are patients of Federally Qualified Health Centers (FQHCs) in six Rhode Island Health Equity Zone (HEZ) communities with the highest need as well as persons who are being discharged from State Department of Corrections facilities. If this grant is funded, a cadre of 12 Health Educators and 12 Health Navigators will work in the designated sites, and SIM Test Grant funds will be used to provide ongoing training to this workforce. If the grant is not funded, SIM dollars will support training programs for existing SBIRT providers throughout the state.

Provider Coaching at Community Mental Health Centers A second investment related to this focus area will be provider coaching. Rhode Island's publicly funded Community Mental Health Centers (CMHCs) are "health homes" for persons with serious mental illnesses. These CMHCs are also involved in a Federal Planning Grant designed to change their status to Certified Community Behavioral Health Clinics (CCBHCs). This status could bring new Medicaid funds to the CCBHCs by early 2017 if our state is successful in bidding for a two-year Federal pilot project. CCBHC status will increase the CMHCs' capacity to serve individuals of all ages with mental health and substance use disorders. As CCBHCs, they will increase the integration of behavioral health and physical health care and boost their use of evidence-based practices. CMHCs are also adapting to new payment methods, moving from fee for service to bundled rates with consumer outcomes as key. Through a competitive Request for Proposal (RFP) process, expert coaches will be selected to help the CMHCs navigate change. The RFP will focus on a three year project, with coaching resources provided with greater intensity in the first year and phasing out over the second and third years. With rapid changes, CMHCs need outside coaching and support to build skills in many areas including:

- Clinical practices, such as connecting more effectively with primary care providers;
- Health information technology uses and benefits;
- Collection and measurement of data; and
- Quality improvement practices.

This project is well matched with our Integrated Health Homes initiative at BHDDH, and we will ensure that we work together to align our goals for both of them.

Care Management Dashboards An additional priority for the SIM Test Grant will be deployment of advanced technology to build a real-time communication system between Rhode Island hospital providers and CMHCs, mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. Specifically, SIM funds will be used for the development of an electronic dashboard that delivers real-time, encrypted notifications to the CMHCs when consumers under their care experience a hospital emergency department or inpatient encounter. The goal is to put critical health information in the hands of the appropriate providers at exactly the right time. This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs. In addition to development of the dashboard tool, SIM Test Grant funding will cover the cost to train providers in use of this new technology.

Healthcare Quality, Measurement Reporting, and Feedback System

As part of the Rhode Island SIM Test Grant, the state convened a Technology Reporting Workgroup based on directive from the SIM Steering Committee. The workgroup is led by the State Health Information Technology (HIT) Coordinator and the HIT Specialist hired specifically for SIM. This workgroup began meeting in January, 2016 and consists of representatives from state agencies, payers, provider organizations, and quality improvement organizations. The workgroup also conducted a survey of healthcare providers in the state in order to receive additional input on the concept of a centralized quality measurement, reporting, and feedback system. The Technology Reporting Workgroup recommends using SIM funding for the development of a statewide quality reporting system with the goals of:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures;
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum;
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health;
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting;
- Publically reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions; and
- Using existing databases, resources and/or systems that meet our needs, rather than building from scratch.

Patient Engagement Tools and End-of-Life/Advanced Illness Care Initiative

In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest funds to provide patients access to tools that increase their involvement in their own care, including:

- Creating the infrastructure and strategies to allow patients to be more actively involved in their own care across their entire life course. One SIM project in this area is to allow patients to more easily share their advanced care directives and healthcare proxies with their providers;
- Developing patient engagement tools such as health risk assessments; and
- Implementing tools that measure consumer satisfaction as well as behavior change readiness.

SIM convened a Workgroup of community members and experts to help us determine our desired parameters and scope for our investments. Members discussed the criteria by which we would select engagement tools, approaches and services, as well as the metrics to be used to assess the degree of engagement with individuals and with the population as a whole. The group has agreed to continue to assist SIM in preparing for a procurement process through which we can identify the patient engagement projects reflecting creativity and best practices

Data Capability

HealthFacts RI

The Rhode Island SIM Test Grant will invest funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named HealthFacts RI. The purpose of HealthFacts RI is to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. It will also provide state agencies and policy makers with the information needed to improve the value of healthcare for Rhode Island residents. It will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities. HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers who cover at least 3,000 individuals in Rhode Island. This information allows users to benchmark and track Rhode Island's health care system in ways that were previously not possible, such as evaluation hospital readmissions, total cost of care, and utilization of preventive or disease management services.

Through the Rhode Island SIM Test Grant, HealthFacts RI will be used to help the state better understand the healthcare delivery system by:

- Identifying areas for improvement and growth in the healthcare system;
- Understanding and quantifying overall health system use and performance;
- Evaluating the effectiveness of policy interventions; and
- Assessing the health of communities.

Statewide Common Provider Directory

Payers, providers, and consumers alike need access to accurate provider information. This information ranges from current name, address, and contact information, to specific health plan network information or direct e-mail addresses. In order to maintain accurate provider directories for facilitating payment, care coordination, data analysis (such as with the HealthFacts RI), or health information exchange (HIE), each type of organization expends considerable resources attempting to maintain their own internal provider directories. Additionally, per legislation, Rhode Island's HIE now offers three consent options for providers regarding the visibility of their data: in emergencies only, for all providers, or for only specific providers. Facilitating this last option for only specific providers' visibility on a participants' data requires an accurate provider directory be in place. Finally, there is no central location from which to quantify the number of providers within the state and to which organizations they are affiliated.

Using SIM funds, Rhode Island has contracted with its state designated entity for HIE to build a Statewide Common Provider Directory. This directory will consist of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans. The intent of this project is to:

- Allow for the mastering and maintenance of provider information and organizational relationships to only occur once in the state in a central location;
- Provide a web-based tool that allows a team of staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers;

- Develop and institutionalize the appropriate data mastering and maintenance system to allow for useful data export via a flat file to ensure readiness for a June, 2016 launch;
- Provide iterative data exports that allow for hospitals, payers, and state agencies to incorporate the centrally-mastered provider data within their own databases; and
- Increase data availability and transparency with a provider portal and a consumer portal. The design of these portals will take place in 2016, with the anticipated go-live in early 2017.

Rhode Island's Integrated Health and Human Services Data Ecosystem

Rhode Island lacks a modern system for integrating person-level information across our EOHHS agencies (Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Human Services (DHS), and the Department of Health (RIDOH)), and then turning that holistic information into action. These agencies share a mission of providing essential services, safety net support, and public health promotion, while often serving the same people and collecting large amounts of data on these beneficiaries. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.

With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data. Rhode Island is planning a light, simple and adaptive solution.

Our approach will build on an ongoing assessment of our entire data ecosystem, which includes our current data warehouse and our processes for collecting, managing, and using data, as well as lessons learned from other states. Funding from SIM will support a transitional vendor to guide our development of an in-state, hosted solution. We will also work with the vendor to develop a complete modernization staffing and structure plan to guide the state during the transition to full ownership of the solution.

Other System Transformation Components

Measure Alignment

Quality measurement and improvement are integral components of value-based contracting. As value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, in June 2015, the SIM Steering Committee charged a workgroup comprised of payers, providers, measurement experts, consumer advocates, and other community partners to develop an aligned measure set for use across all payers in the state.

The final product was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). See appendices for additional information and measure specifics.

Regulatory Levers

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work. Starting on Page 184, we

have described the key regulatory levers held by our participating state agencies that we will use to help us reach our goals. For example, to facilitate us moving toward our goal of 80% of payments linked to value by 2018, we will use OHIC's Affordability Standards. The standards hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting.

In another example, Medicaid contracts with Managed Care Organizations (MCOs) and pays them a capitated rate for Medicaid enrollees across different programs. In turn, Medicaid imposes conditions on the MCOs through contracting. The contracting conditions structure how MCOs reimburse providers, measure quality, and support multi-payer programs, such as the state's multi-payer patient-centered medical home program. As stated in the Rhode Island Healthcare Transformation Plan, Medicaid will use the MCO contracting mechanism to impose specific annual targets for use of APMs by the MCOs, and directives to contract with credential Medicaid Accountable Entities.

Multi-Sector/Multi-Agency Integration & Alignment

Rhode Island's size provides us with a set of opportunities and challenges. The challenges include an economy that must rely on a relatively smaller set of economic drivers than those found in larger states, and a healthcare system that is thus a higher percentage of our economy than in other states. However, our small size provides us with a number of positive opportunities, including the strong relationships that we can build statewide between existing and new interventions.

The number of federal- and state-funded initiatives listed beginning on Page 195 of this plan show that we do have a significant level of reform activities underway. It is often easier for state departments to carry out the grants they have received or the statutory requirements they must fulfill without taking the time to align with other projects. However, the SIM Interagency Team provides us with a forum to share this information and to ensure that state agency activities can be as aligned as possible with each other – to maximize the value of the interventions, serve more people, avoid duplication, and save money.

Therefore, we have determined that one of the main articulated strategies of Rhode Island's SIM project will be to pursue a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. The SIM convened workgroups bring people from multiple agencies and backgrounds into the same room to collaborate and plan together. One major benefit of this collaboration is that needs of all agencies are discussed during the planning phase of our projects, meaning that the end result will be more likely to meet each stakeholder's needs.

For example, the Patient Engagement Workgroup has brought together a variety of stakeholders including all of our SIM state agencies and will determine a clear set of the highest priorities for patient engagement in the state. This allows all voices and needs to be heard and will result in a very different end result than if only one agencies had determined the type of patient engagement activities to procure. It will also mean that if an agency's priority is not chosen to be developed, representatives from that agency will have a better understanding of why and may agree with the decision.

Several areas for alignment and collaboration come from the Rhode Island Department of Health (RIDOH). RIDOH has a well-established, evidenced based Family Visiting program which provides supports and referrals to pregnant women and mothers of children up to age 3.

The RIDOH team has offered to share best practices and lessons learned as SIM invests in new Community Health Teams, which will also work to connect Rhode Islanders with community resources and clinical support as needed.

RIDOH recently completed a Statewide Health Inventory, examining utilization of healthcare services and the capacity of providers to offer needed care. Among the findings was a lack of consistent data about patient demographics – providers rarely collected information about patient race/ethnicity and primary language. RIDOH's Commission on Health Advocacy and Equity has reported a similar lack of data on patient demographics. This data gap has made it difficult to paint an accurate picture of existing health disparities. To address this issue, the SIM team plans to develop standard demographic and social determinants of health related data requirements in all of its procurement contracts. In addition, the Measure Alignment Workgroup will consider adding the same or a subsection of those measures to its core measure set.

RIDOH is also in the process of developing a standard set of metrics to evaluate its Health Equity Zones (described in detail on page 201 of this plan) and its other Community Health Assessment projects. Instead of developing a different set of metrics, RIDOH will use the SIM population health measures (described in Appendix 2) and metrics described in the IPH to guide its evaluation work.

Another example that we have described elsewhere in this document is the system transformation goals set by OHIC. When Medicaid began to build its Accountable Entity program, SIM set up a dialogue between the two agencies resulting in Medicaid adopting OHIC's language on APM implementation.

One last example is our collaboration on the Provider Directory. The Provider Directory will be a very versatile tool that serves a variety of clients, including state agencies, consumers, providers, payers, and numerous organizations. Collaboration and alignment across agencies helps to prioritize certain functionality when many ideas come to mind.

One proposed Provider Directory collaboration has the potential to address the prevalence of obesity in Rhode Island. As the Population Health consultant vendors explored initiatives to reduce obesity in Rhode Island, local experts mentioned that doctors are often reluctant to diagnosis patients, especially children, with obesity. This reluctance comes from a lack of knowledge about how to refer their patients to weight reduction experts. As a result, the SIM team will propose prioritizing nutritionists and dieticians among the specialists to include in its Provider Directory. This addition will give physicians the ability to quickly find licensed experts who can help their patients reach a healthy weight.

In addition, some discussion has begun about adding functions to the Provider Director that will help with care coordination and tracking at the practice level as well as referral system to help route, track, and close the referral loop. An interagency team will help ensure that these functions meet the needs of EOHHS, BHDDH, OHIC, RIDOH, and our community stakeholders.

This alignment will stem from good, ongoing communication between agencies, facilitated by the SIM process that has been embraced by seven state agencies to this point, and can be joined by other related state departments. For example, as SIM builds up its activities on social and environmental determinants of health, we will be reaching out to the Departments of

Environmental Management and Transportation. Both of these departments already have engaged with RIDOH as members of the RIDOH Commission for Health Advocacy and Equity.

Over the next three years, we have the opportunity to bring their topic areas into the larger SIM portfolio, to lift up the types of conversations that will bring about a "health in all policies" orientation to state government – i.e. the importance of play space for youth to counter obesity and more public transportation to medical practices as a facilitator of health access.

Workforce Development

Fundamental to restructuring the healthcare delivery system and achieving the Triple Aim is the development and support of a workforce that has the training, knowledge, and experience necessary to deliver healthcare and wellness services in new and innovative ways. This is likely to entail new job titles, new duties, new work settings, and new skill sets for healthcare employees. This "workforce transformation" cannot and will not be achieved by a single healthcare provider, educational institution, or payer. Rather, it will take an unprecedented collaborative and visionary approach by all stakeholders to identify and implement new workforce development strategies that will successfully address the current and projected workforce needs of healthcare providers and the community at-large.

The Rhode Island Executive Office of Health & Human Services has recently demonstrated its commitment to aligning healthcare workforce development and delivery system transformation by creating the position of Director of Healthcare Workforce Transformation, which will be responsible for developing and overseeing the implementation of a healthcare workforce transformation plan for the state. This workforce planning process will engage a multi-stakeholder Healthcare Workforce Transformation Workgroup (HWTG) comprised of key stakeholders (described in the Workforce Capacity Monitoring section of this plan below). The HWTG will be the guiding force behind SIM's research, monitoring, and workforce planning activities with a focus on meeting the education and training needs of the current workforce as well as new entrants and addressing barriers to achieving workforce transformation. The HWTG will also become a communications network, to ensure that all partners are aware of industry needs and opportunities.

Workforce outcome targets will be based upon a detailed assessment of the current healthcare workforce "supply" (i.e., occupations, settings, education, demographics, etc.) and the current and projected healthcare workforce "demand" (i.e., current and projected vacancies, occupations, settings, education, etc.). We will develop and refine our outcome targets over the next six months through an iterative and collaborative process that will engage healthcare educators and providers in designing, implementing, evaluating, and revising innovative healthcare workforce development initiatives.

Evaluation

There are three parts to our SIM evaluation plan:

1) SIM leaders and staff will participate in the federal evaluation being undertaken by RTI. We expect three site visits, and regular monthly communications with the evaluation team.
2) SIM will retain professional outside evaluators to carry out a focused evaluation on the effectiveness of our project. We are in the process of preparing our procurement process for this vendor. They will be chosen through a competitive Request for Proposals (RFP). One particular part of this evaluation process is a project recently approved by our Steering Committee to document and compare the effects of Alternative Payment Models

in use in the state. The purpose would be to learn how the models work, what related activities most support their success, and whether alignment of models across payers and providers would yield a greater impact on desired outcomes.

3) SIM will carry out regular in-house monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process. One specific evaluation activity will be a study on the Return on Investment for SIM-supported CHTs and the Consolidated Operations Model.

As we procure and begin to work with our professional evaluator, we will determine the scopes of each of these efforts, to ensure that they are complementary but not duplicative. We plan for a mixed method evaluation – both qualitative and where possible, quantitative. We know that we have information that we must report to CMS and CMMI, and our in-house evaluation work will be in service to those requirements. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

SIM Component Summary Table

Table 5: Component Summary Table

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Planning and Governance					
SIM Steering Committee	The SIM Steering Committee is the public/private governing body for Rhode Island's SIM project. The committee's primary function is to set strategic direction, create policy goals, approve the funding plan, and provide oversight over the implementation of the SIM grant. The committee meets monthly and is comprised of community stakeholders who represent health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations.		N/A	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
SIM Project Director and Staffing Across Five Partner Agencies	Staff at each participating state agency will carry out day to day functions of the SIM project and work together on the SIM Interagency Team. Participating state agencies are: Executive Office of Health and Human Services (EOHHS), Office of the Health Insurance Commissioner (OHIC), Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), Department of Health (RIDOH), and HealthSource RI. We also work closely with the Department of Children, Youth, and Families, but they do not have a dedicated SIM staff person.		$3,000,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Project Management Vendor	The Project Management Vendor (UMASS) manages SIM related project management activities including support for stakeholder management, project meetings, data collection, risk management, communications, sub-contractor management, and work plan management.	University of Massachusetts Medical School	$1,600,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Rhode Island Health System Transformation					
Transformation through regulatory action and payment reforms	Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value[1] with a regulatory strategy to achieve these goals. OHIC also has targets for care transformation, as reflected on Page 204.	N/A – Carried out by OHIC and Medicaid	In-kind by OHIC and Medicaid	Create measureable improvements in Rhode Islander's physical and mental health.	Percentage of payments made under an APM. Percentage of payments linked to value.

[1] Rhode Island will track payments linked to value by crediting the total dollar value of provider contracts with performance-based incentives (such as P4P) toward the numerator of the ratio.

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Investing in Rhode Island's Healthcare Workforce and Practice Transformation					
Community Health Teams	Community health teams (CHTs) currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs improve population health by addressing social, behavioral, and environmental needs. Our SIM-funded teams will also support providers in transitioning to value-based systems of care; and help transform primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures. In order to maximize improvements in Rhode Island's population health, address and improve our social and environmental determinants of health, and make progress in eliminating health disparities within our state, CHTs services should be available to all Rhode Islanders who need that level of multi-disciplinary, community-based services to address the factors that impact our health. In particular, SIM will fund two areas of work for CHTs in Rhode Island: Building the capacity of current teams to serve their patients more effectively, and supporting up to two new CHTs. The new CHTs will be multi-disciplinary (including behavioral health providers and community health workers); connected to a provider within a certain geography; accessible to all regardless of insurance; and reflective of the diversity of the communities they serve.	To be determined through a competitive RFP process	$2,000,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Number of active SIM-funded CHTs Percent of new, SIM-funded CHTs actively seeing patients Number of unique practices utilizing new, SIM-funded CHTs Number of CHTs participating in the statewide CHT consolidated operations model Percentage of completed data reports submitted by consolidated operations team Number of provider trainings delivered about practice transformation and CHT benefits Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded) Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination Number of Community Health Workers certified through the Rhode Island Certification Board Percentage of CHTs employing Certified Community Health Workers

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
					Number of patients in provider panels with referral ties to SIM CHTs
					Percent of RI residents with access to CHT (SIM funded + Existing)
Child Psychiatry Access Program	The Pediatric Psychiatry Referral Consultation project will establish a children's mental health consultation team to support pediatricians and other primary care doctors serving children and adolescents with mental health conditions. The Access Program is designed to assist the pediatricians and other physicians to treat children with behavioral and mental health needs in a way that is preventive and responsive to a patient's immediate circumstances. This consultation, support and response to emergent situations will be invaluable for families. This project will also provide ongoing physician training to ensure that the delivery of care for children and adolescents can be in the least restrictive setting possible.	Pursuing single source procurement	$650,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services
					CUM # of patients served under the child psychiatry access program
PCMH Kids	PCMH-Kids builds off of the successes of Care Transformation Collaborative in Rhode Island (CTC-RI), the adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of primary care practices in Rhode Island to children by engaging providers, payers, patients, parents, purchasers, and policy makers to develop high quality family/youth/children-focused PCMHs that will assure optimal health and development. PCMH-Kids is convened by the state's Executive Office of Health and Human Services (EOHHS) and Medicaid program, with participation from all four major health plans. Nine pilot practices have created a common contract with payers and are receiving supplemental payments and on-site, distance, and collaborative learning and coaching to support practice transformation and quality improvement. SIM funding for PCMH-Kids will include support for practice facilitation and coaching, practice assistance with reporting and analyzing data, and overall program evaluation.	Pursuing single source procurement	$500,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practices participating in the pediatric PCMH program
					CUM # of clinicians participating in the pediatric PCMH program
					CUM # of patients attributed to practices participating in the pediatric PCMH program

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Behavioral Health Transformation: *Integrated Behavioral Health*	The Rhode Island SIM Test Grant will fund a qualified provider with experience and skill in helping primary care practices, representing multiple payers, to integrate behavioral health care into their clinical work. The qualified provider will have expertise facilitating within primary care practices: 1) depression, anxiety and substance use screening; 2) collaboration of behavioral health specialty staff with nursing/physician personnel; 3) use of behavioral health subject-matter expert(s) to support training and development efforts; and 4) development of knowledge about appropriate measurement and quality assurance activities.	Pursuing single source procurement	$370,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practice sites participating in integrated behavioral health initiative
Behavioral Health Transformation: *SBIRT*	Rhode Island seeks to decrease the use of tobacco, alcohol and other drugs. The Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) has just received a Collaborative Agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) grant from the Substance Abuse and Mental Health Service Administration (SAMHSA). This grant will allow us to provide alcohol, drug and tobacco screening to 250,000 adults (one-quarter of Rhode Island's population) over five years. As needed, referrals will be made to brief interventions or treatment. Priority populations are individuals living in designated high need areas and persons leaving Department of Corrections' facilities. It is our plan that SIM Test Grant funds will support ongoing training to a 24 person workforce of Health Educators and Navigators to ensure that the two projects are well-aligned. If	To be determined, once we learn the outcome of the SAMHSA grant	$480,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of providers who have been trained in SBIRT
Behavioral Health Transformation: *Provider Coaching*	Another behavioral health investment will be provider coaching. Rhode Island's publicly funded Community Mental Health Centers (CMHCs) are "health homes" for persons with serious mental illnesses. SIM Test Grant funds will be used to support an expert coaching program to help CMHCs improve their effectiveness in addressing consumers' health care needs. Expert coaches will help CMHC staff: 1) improve clinical practices, such as connecting more effectively with primary care providers; 2) learn health information technology uses and benefits; 3) collect and measure data; and 4) strengthen quality improvement practices.	To be determined through a competitive RFP process	$1,200,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs that received provider coaching

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Behavioral Health Transformation: *Care Management Dashboard*	The SIM Test Grant will fund a real-time communication system between Rhode Island hospital providers and CMHCs, mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. An electronic dashboard will deliver real-time information to the CMHCs when their consumers have a hospital emergency department or inpatient encounter. This effort will support targeted, clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs. In addition to development of the dashboard, SIM Test Grant funds will cover training to providers in use of this new technology.	Pursuing single source procurement	$150,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs with real-time ED and inpatient dashboards in use CUM # of providers trained to use dashboards at CMHCs
Integrated Population Health Plan	Rhode Island aims to achieve measurable improvement in the health and productivity of all Rhode Islanders. To achieve this aim, the healthcare delivery, public health, community development, and social service sectors as well as the many academic, public, and private institutions in our state will work together to ensure that all Rhode Islanders are able to achieve their highest health potential, without system/structural barriers. This population health improvement effort requires multi-sector/multi-agency collaborations to help us transition from an uncoordinated, healthcare provider and payer-centric care focused health services environment to an environment where public health, social service, and healthcare delivery systems are well-integrated as well as outcomes-oriented and person-centric. Although the Integrated Population Health Plan focuses on specific physical and behavioral health conditions or diseases, our aim is to create an approach that centers on wellness, not disease. As the plan evolves, our strategies will move towards methods that help Rhode Islanders live long, productive and healthy lives, addressing them not as patients but as people. Our approach to population health improvement focuses on health across the life course (from birth to death) from the perspective of the “whole-person" and includes behavioral health, where behavioral health includes mental health and substance use disorders. It is a population health vision, with the goals of improving the health and wellbeing of all Rhode Islanders; to promote “any door as the right door” to identifying mental illness and substance use disorders early and providing the supports and interventions to enable people to recover rapidly; to create healthy, resilient inclusive communities throughout Rhode Island, and to ensure that persons with physical or behavioral health conditions, including severe and persistent mental illness and/or addictive disease, have access to evidence-based services that support recovery and full inclusion in their communities in the least restrictive setting possible.	University of Massachusetts Medicaid School sub-contractors The Providence Plan (ProvPlan) and the Technical Assistance Center (TAC)	Funded within the Program Management vendor line for subcontractor consultants	Create measureable improvements in Rhode Islander's physical and mental health.	N/A

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Healthcare Quality, Reporting, Measurement and Technology Feedback	Based on significant stakeholder input, SIM will fund the development of a statewide quality reporting system to help providers "enter data once and analyze many time." Our goals for the reporting system are to improve the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures; produce more valuable and accurate quality measurements based on complete data from the entire care continuum; leverage centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health; reduce the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting; publically report quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions; and use existing databases, resources and/or systems that meet our needs, rather than building from scratch.	To be determined through a competitive RFP process	$1,750,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system. CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.
Patient Engagement					
Patient Engagement	In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest funds to provide patients access to tools that increase their involvement in their own care, including creating the infrastructure to allow patients to more easily share their advanced care directives and healthcare proxies with their providers; developing patient engagement tools such as health risk assessments; and implementing tools that measure consumer satisfaction as well as behavior change readiness.	To be determined through a competitive RFP process	$1,700,000	Provide access to patient tools that increase their engagement in their own care.	Metric(s) in development.
End-of-Life/ Advanced Illness Care Initiative	We know that patients and providers both avoid discussions about end-of-life planning, leading to unwanted medical care and family distress. SIM will fund Advance Care Planning Discussion trainings, to support providers in carrying out patient engagement activities in the event of advanced illness. The program will promote effective collaboration between patients, families, and providers in making healthcare decisions; improve health literacy among patients and their families; and provide opportunities for participants to complete advance directives.	Pursuing single source procurement	$500,000	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Metric(s) in development.
Increasing Data Capability and Expertise					
HealthFacts RI	The Rhode Island SIM Test Grant is investing funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named “HealthFacts RI.” HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers who cover at least 3,000 individuals in Rhode Island. This information allows users	Freedman Healthcare, OnPoint, and 3M	$2,039,673	Increase use of data to drive quality and policy	# of publically available reports released from HealthFacts RI per year

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
	to benchmark and track Rhode Island's health care system in ways that were previously not possible. When fully implemented, HealthFacts RI will ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. It will also provide state agencies and policy makers with the information needed to improve the value of healthcare for Rhode Island residents and will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities.				# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year
Statewide Common Provider Directory	Payers, providers, and consumers all need access to accurate provider information. Using SIM funds, Rhode Island has contracted with its state designated entity for HIE to build a Statewide Common Provider Directory. The provider directory is a database with a web-based tool that allows a staff team to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers. It will consist of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans.	Rhode Island Quality Institute	$1,500,000	Increase use of data to drive quality and policy	CUM # of state agencies using common provider directory CUM # of private sector health care organizations using common provider directory
Integrated Health and Human Services Data Ecosystem	Rhode Island lacks a modern system for integrating person-level information across our agencies and then turning that holistic information into action. While EOHHS has built a data warehouse that stores many different sources of data – in addition to separate data sets that live within each agency – there is limited capacity to first connect and then share those linked data, either at the person level or in the aggregate. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources. With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data. This approach differs from a traditional, expensive and "all at once" Data Warehouse project that is common to many data integration initiatives. Rather than seek to purchase or build a large system that will attempt to integrate all data and develop user interfaces that satisfy many user needs – a process that could take years, come with high upfront costs, and that would rely on our existing knowledge to guide design and decision making – Rhode Island is planning a lighter, simpler and more adaptive solution.	To be determined through a competitive RFP process	$1,800,000	Increase use of data to drive quality and policy	N/A

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Other System Transformation Components					
Measure Alignment	Quality measurement and improvement are integral components of value-based contracting. As value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, between June 2015 and March 2016, the Measure Alignment Workgroup created by the SIM Steering Committee created an aligned measure set with 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). The workgroup was made up of up payers, providers, measurement experts, consumer advocates, and other community partners. The next step is for OHIC to create the implementation process for the measures and for the workgroup to create a governance process for annual review and updating of the set.	Bailit Health Purchasing	Included in Project Manager Line Item	Increase use of data to drive quality and policy	N/A
Regulatory Levers	Rhode Island is committed to using our multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work, identifying the regulatory abilities they have now to move the payment system, support providers and patients, and thus improve population health and address costs. For example, OHIC's Affordability Standards described within the Operational Plan on Page 204 hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting;	Conducted by staff	N/A	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Multi-Sector/Multi-Agency Integration and Alignment	Rhode Island's small size provides us with a number of positive opportunities, including the strong relationships that we can build statewide between existing and new interventions. The large number of reform interventions in the state are significant – and the SIM table provides us with a forum to share this information and to ensure that state agency activities can be as aligned as possible with each other – to maximize the value of the interventions, serve more people, avoid duplication, and save money. Therefore, we have determined that one of the main strategies of Rhode Island's SIM project will be to pursue a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities.	Conducted by SIM leaders and staff	N/A	Create measureable improvements in Rhode Islander's physical and mental health.	TBD

SIM Component Summary Table					
Component & Activity/ Budget Item:	**Description of activities**	**Vendor** (If known)	**Expected Expenditures**	**Primary Driver**	**Metric**
Workforce Development	Fundamental to restructuring the healthcare delivery system and achieving the triple aim is the development and support of a workforce that has the training, knowledge, and experience necessary to deliver healthcare and wellness services in new and innovative ways. This is likely to entail new job titles, new duties, new work settings, and new skill sets for healthcare employees. This "workforce transformation" cannot and will not be achieved by a single healthcare provider, educational institution, or payer. Rather, it will take an unprecedented collaborative and visionary approach by all stakeholders to identify and implement new workforce development strategies that will successfully address the current and projected workforce needs of healthcare providers and the community at-large.	Conducted by SIM Staff and the Healthcare Workforce Transformation Committee	N/A	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	TBD
Evaluation					
Evaluation	SIM will retain professional outside evaluators to carry out part of our evaluation process, but we will be monitoring and evaluating the milestones and metrics we identify in-house as well. The Steering Committee has also approved a learning collaborative process to study the efficacy of value-based payments to increase quality, improve population health, and lower costs. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of evaluation well.	To be determined through a competitive RFP process	$700,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A

SIM Sustainability Strategies

The sustainability of the SIM project is of great concern to CMS and to Rhode Island's SIM leadership. Rhode Island recognizes that the lasting power of the Model Test is the ability to continue the efforts at the end of the funding period. For that reason, as described in the narrative and the operational plan, our goal has been to invest in infrastructure and one-time expenses that will lead to a health system transformation. While a portion of our budget does support on-going programming, we have aimed to include a sustainability path, such as a training component (so that staff will retain the knowledge) or a means to future funding through savings or expected carrier reimbursement. The chart below describes the sustainability strategies we have developed up to this point for the funded SIM activities (except the SIM Evaluation, which is time-limited). We will continue to make the development of these strategies a high priority as we move forward into Year 2.

Table 6: SIM Sustainability Chart

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Community Health Teams	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Collect data to determine cost effectiveness of consolidated operations and overall ROI. If ROI is significant, would pursue funding from ACOs, infrastructure payments from carriers (through negotiations), or netted out of shared savings.	Proof that CHTs provide higher quality care and added-value to the practices with which they partner. Proof that CHTs are an essential role for improving care coordination and responding to specialized needs within a less restrictive setting. Elimination of barriers, infrequent care, and lack of access to preventive services by CHTs are keeping individuals out of the ED and/or avoiding readmission.
Child Psychiatry Access Program	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Explore ROI – does the program keep children out of less restrictive setting?	Children who are cared for in their PCP's offices rather than in EDs or hospitals. PCPs who are more confident in their ability to treat children with behavioral health issues. More integration between physical and behavioral health in PCP offices.
PCMH Kids	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	If the 9 practices successfully transform (by OHIC's standards), carriers plans will continue to support their ongoing care management and provide quality incentives.	At least 20 additional practices will come through the initiative and be working on transformation to meet OHIC's standards.

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Behavioral Health Transformation: *SBIRT*	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	With recent award of a SAMHSA SBIRT grant, this project is secured for 5 years. Through the 5-year project, Rhode Island will explore ROI, create an ongoing train the trainer programs to ensure that the program continues, build it in to the Practice Transformation coaching for the CMHCs and the PCMH training, and explore carrier reimbursement.	Improvement in behavioral health outcomes of people with substance use disorders. Increased access to screening services to adults within primary care/ health clinic settings, emergency care/health clinic setting, EDs and the Department of Corrections. IT strategies in place so providers can access and score SBIRT questionnaires centrally or through their own Electronic Health Records and share SBIRT results through Current Care for enrolled individuals.
Behavioral Health Transformation: *Integrated Behavioral Health*	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Evaluation plan to help determine cost savings from reduced ED and inpatient use and how those savings can be deployed to sustain ongoing behavioral health integration in health care settings.	Increasing numbers of primary care practices with integrated behavioral health providers on-site. Improvement in scores for anxiety, depression and substance use for persons served by primary care practices that integrate behavioral health care. ED and inpatient savings through reduction in behavioral health symptoms that drive medical/ behavioral health utilization and cost
Behavioral Health Transformation: *Care Management Dashboards*	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	One-time payment for dashboard development. CMHCs are expected to pay for maintenance.	CMHCs will have the data they need about patients just admitted for hospital stays or being discharged from the hospital stays. With one in five hospital stays having a behavioral health component, this knowledge will allow CMHC staff or CHTs to communicate with their patients, to help patients follow discharge protocols and avoid additional hospital stays.

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Behavioral Health Transformation: *Practice Coaching at Community Mental Health Centers*	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	The design of this program can ensure that the investment in provider coaching will be built into the infrastructure of the CMHCs for up to 10 years. This includes train the trainer – a ladder of training so that staff turnover will not affect the institutional knowledge. We will develop training manuals that can be consulted by staff, and ongoing refresher courses throughout SIM's 3 years.	CMHC staff learn to incorporate health care coordination into their behavioral health practices, with demonstrated results to include, for example, reduction in rates of smoking, reduction in BMI; increased evidence of healthy eating habits and participation in regular exercise. Overall increase in self-reported quality of life and decrease in expensive inpatient care. (This is a reworking of the primary driver in this case, because instead of integrating behavioral health into primary care, we are integrating primary care into behavioral health.)
Healthcare Quality, Reporting, Measurement and Technology Feedback System	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	We expect that this feedback system will be of significant use to providers transitioning to QPP – and that they will find it cost-effective to pay for its services after SIM's initial investment to build and refine it.	Providers will have the data in a format that allows them to easily use it for quality improvement, learning about best practices among peers, and whole-person care of their patients. Consumers will have access to quality transparency to increase their engagement in healthcare choices.
Patient Engagement	Provide access to patient tools that increase their engagement in their own care.	Patient Engagement – We will create the sustainability models as we continue our planning and RFP creation for patient engagement. We will also ask our vendors to build in sustainability planning into their approach.	Patient Engagement – While the specific of our goals for patient engagement will be developed as we continue our planning, our overall definition of success will be that patients are more able to take ownership of their care and improve their health.
End-of-Life/Advanced Illness Care Initiative	Assist with advanced illness care planning by promoting end-of-life conversations in the primary care setting.	End-of-Life Initiative – Just as we plan for the Practice Coaching at CMHCs to create long-term capacity within the agencies, we will build in a significant train the trainer program to maximize the long-term value of the training and group support provided through this program.	End-of-Life Initiative – We will see an increase in the number of primary care provider/patient conversations concerning advance care planning, an increase in the documentation of advance care planning, a decrease in unwanted utilization of services among those with advanced illnesses, and improved comfort levels among providers and patients and their families.
HealthFacts RI (Rhode Island's All-Payer Claims Database)	Increase use of data to drive quality and policy	Datasets from HealthFacts RI will be valuable for various research projects, business analytics, and informing healthcare policy. Data will be sold to interested parties, and the value of the data may help make the case for funding any remaining shortfall from the state budget.	Datasets are regularly shared with customers through an efficient data release process, expanding the possibilities for learning we can have collectively as a state from the data. Consumers have access to cost data to inform healthcare decisions and increase engagement in their care.

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Statewide Common Provider Directory	Increase use of data to drive quality and policy	SIM is funding the initial build and data model design for the provider directory. When operational RIQI will provide extract files for a fee.	Meaningful and accurate provider directory that tracks organizational relationships over time and supports the states' and community's needs. Consumers can search for providers in one place to meet a variety of needs, such as selecting a health plan, finding a physician that can speak their language, etc. Overall it is very important that stakeholders have confidence in the accuracy of the data.
Integrated Health and Human Services Data Ecosystem	Increase use of data to drive quality and policy	The initiative aims to both train existing state and hire critical employees to complete the staffing needs. If ROI is proven and project leadership are confident in the state's ability to maintain the system after the vendor exit, the state will move to incorporate the positions into the general budget and leverage the capital budgeting process to fund future hardware and software needs.	1.) Several critical EOHHS data sets are linked at the person level. 2.) Vendor has built a scalable and transferrable master client index 3.) The newly integrated data is being used to enhance the structure and interventions of ACOs and AEs 4.) The integrated data is being used to more holistically measure population health and potential high risk clients who are unattributed to an ACO or within an ACO and showing excessive use of acute or unnecessary services
System Transformation	Create measureable improvements in Rhode Islander's physical and mental health.	Rhode Island's system transformation plan exists within the regulatory structure of OHIC and Medicaid. SIM is providing ways to more fully integrate the two arenas of work, to carry out significant evaluations of the transformations with evaluation dollars, and to lift up the system changes to a wider audience.	A health system where 80% of payments are linked to value and 50% are under an APM.
Workforce Development	Create measureable improvements in Rhode Islander's physical and mental health.	Medicaid match, TBD	A workforce system more prepared for our value-based system.

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Multi-Sector/Multi-Agency Integration & Alignment	Create measureable improvements in Rhode Islander's physical and mental health.	The structure of our staffing – that we have embedded SIM staff members in each agency rather than having them work out of one SIM office – means that we are purposefully sharing the SIM integration and alignment priorities throughout state government. Our Integration & Alignment project will also allow us to use these three years with significant state staff to cultivate relationships among state agencies and between state agencies and private community organizations that can continue on beyond the SIM grant period.	SIM activities are carried out effectively and are seamlessly melded into other state agency work
Evaluation		N/A	A deep understanding of our system changes, how APMs will continue to work to reform our healthcare system, and a guide to what SIM activities should be continued with state or other funding

Risk and Mitigation Strategy

Rhode Island has been pursuing health transformation for many years, and the SIM Test Grant builds on prior research, policy, law, economics, regulation and clinical innovation in healthcare reform. As a small state, we have the opportunity to work closely with stakeholders statewide, often in face-to-face encounters. As we've noted throughout this document, Rhode Island has a strong tradition of collaboration between federal, state, local, academic, business, and community stakeholders to identify issues and seek collaborative solutions.

Accordingly, we are aware of risks and issues that may affect the success of the SIM Test Grant project in the state, and are working actively to mitigate those risks.

Approach

The Rhode Island SIM team has created a risk and mitigation matrix based on standard project management practice, where each risk is assessed based on likelihood of occurrence, impact of occurrence, and assigned a 1-5 (low-high) scale value. The likelihood and impact are multiplied to produce a risk score. These scores have no intrinsic meaning, other than to allow relative comparisons of risks.

Risk Mitigation Principles

The following are the general principles that SIM is using to address the risks that we face:

Involvement of a diverse group of stakeholders, with significant communication.
By engaging stakeholders across the spectrum of our work, we increase our ability to call on subject matter experts for assistance in our projects – and decrease the chances that we will encounter problems that we cannot solve. All SIM activities follow Rhode Island's Open Meetings laws, ensuring public notice of all meetings and transparency of meeting proceedings.

Robust and active project management.
Project management was at the top of Rhode Island's priorities when engaging consultants to assist with the SIM Model Test Grant, and the teams are following project management best practices in developing, managing, and tracking activities.

Following evidence-based practices.
We have engaged experts in population health planning and behavioral health planning, as well as measure development and other technical specialties for SIM. Their expertise is being heavily leveraged in researching policies and best practices that can be applied to Rhode Island from within and outside of the state.

Identifying and mitigating risks is an ongoing process. Periodic reassessment is the best means for addressing currently unidentified risks. Success at early and active mitigation may prevent later risks from developing. And the state will be sure to further define additional risk mitigation strategies through our Interagency Team, as we begin to implement our transformation activities in the upcoming months.

Rhode Island has a unique advantage for a project of this size. A large proportion of the stakeholders already know each other and have worked together previously on our long history of healthcare transformation. This has made early SIM work well-informed, collaborative and

efficient. Points of view on issues – even if people are not always in agreement – are usually understood. Methods for problem-solving have been tested, and are effective.

Finally, one of the most significant mitigating factors is that the political leadership in the state is well aligned around the issues and needs for Rhode Island, and they are prepared to work together to meet those needs. As such, they have been strong supporters of the SIM Test Grant, and we expect that support to extend throughout the life of the project.

Risk Register

The Rhode Island SIM team identified ten key risks and the mitigation strategies to address them. They are ordered within Risk Category, then by highest Risk Score in the following table.

Table 7: Risk Register

		Likelihood it will occur	*Impact* if it occurs	Risk Score	
	Risk Category/ Risk	**(1-5)**	**(1-5)**	(=Likelihood X Impact)	**Mitigation Plan**
	Procurement				
1	Deadlines for procurements are missed Purchasing process is lengthy; funds cannot be disbursed and applied to the objectives sufficiently rapidly, making it more difficult to achieve our goals.	5	4	20	Prioritize procurement in our workplan above other projects. The SIM team will work collaboratively and efficiently to minimize delivery time to Purchasing. To that end, SIM team will: • Create a small procurement staff team dedicated to expediting the process end-to-end. • Conduct initial exploration with all approving entities to ensure we understand their rules and process • Meet with Department of Administration leadership to engage them in grant goals and get their commitment to timely purchasing and contract administration Current contractors will be enlisted for support in any processes where there is not a conflict of interest.
2	Inadequate bids on Specific RFPs	3	4	12	Provide thorough bid guidance in RFP. Conduct robust RFP distribution efforts through current stakeholders and the wider state healthcare network
3	Protracted contract negotiations once a vendor is selected	3	3	9	Send out state contract template/terms and conditions with RFP and request that vendors identify what issues they have with the state contract and alternative language when they submit their proposal so the state can be prepared ahead of time for contract negotiations with the vendor.
	Metrics and Measures				
4	Lack of Data Availability to Meet Need	5	4	20	Aggressively pursue data availability early, to establish parameters of what is possible. Work within the state's current data teams and offer to add SIM staffing resources if necessary. Prioritize other data for acquisition at a later time. If there is a lack of data about "net new" or unstudied program activities to identify benchmarks or targets, set targets and reassess at mid-year to determine they reliability and validity. Work with stakeholders to assure access to data at the provider and payer level.

		Likelihood it will occur	*Impact* if it occurs	Risk Score	
	Risk Category/ Risk	**(1-5)**	**(1-5)**	(=Likelihood X Impact)	**Mitigation Plan**
5	Project implementation does not work as planned	5	4	20	Hold regular internal evaluations to assess implementation and find problems quickly. Work with stakeholders to find solutions to the problems without delay.
	Technology & Data				
6	Technology Does Not Exist to Support Needs	4	3	12	Conduct thorough assessment of business requirements; make technical selection based on priorities and cost benefit of build vs. buy. Implement infrastructure that is extensible and scalable and can easily be modified to meet users changing needs
7	Technology or Data is Not in Compliance with Standards	3	4	12	Identify standards before conducting technical assessment
8	IT development lifecycle takes longer than expected.	4	3	12	Set realistic goals during the planning phase, prioritizing activities that must be done by deadlines versus those that can wait. Use iterative IT development life cycle process and implement incrementally so as to accomplish most critical functionality first.
9	Privacy concerns disrupt project plans or timelines	3	5	15	Involve the community of stakeholders in any decisions that may have privacy implications and discuss the potential for duplication of data systems and interfaces as a result of limiting data sharing. Seek to identify how widespread the privacy concerns are to gauge the implications for moving ahead or not and/or identifying alternate options for achieving the same goal.
10	Internal staffing lacks skills to achieve goals	4	3	12	Assess current staff skill levels related to data analytics as well as IT development, incorporate training opportunities for existing workforce, and in any new hiring, choose new staff with needed skillsets to fill in gaps. Leverage staff experience within stakeholder organizations.
	Program Implementation				
11	Challenges achieving our expected program outcomes	3	3	9	Base solutions on evidence. Set clear, concrete goals for initiatives, with achievable objectives and work with our subject matter experts and other stakeholders to address challenges. Provide sufficient funding to achieve success. Ensure robust quality assurance, measures, and metrics capture mechanisms. Carry out regular monitoring of progress, tied to data on quality.

		Likelihood **it will occur**	***Impact*** **if it occurs**	**Risk Score**	
	Risk Category/ Risk	**(1-5)**	**(1-5)**	(=Likelihood X Impact)	**Mitigation Plan**
12	Lack of alignment between federally funded projects and difficulty aligning existing state projects	2	4	8	• Continue outreach to state agencies and community agencies with federal funds, maintaining close contact with stakeholders • Increase sense of ownership by involving stakeholders in incremental policy development process. • If funding is pursued through other sources, maintain contact with those stakeholders. • Active, consistent engagement of executive leadership across the Executive Office of Health and Human Services, OHIC, HealthSource RI, and the Governor's Office
13	Participation in SIM activities by providers or patients does not meet expectations, reducing the chance of achieving expected outcomes				Make and set realistic goals for participation based on historical experience; incorporate stakeholder outreach plans into vendor contracts; increase outreach efforts if participation falls short of expectations
14	Timeline or Timeframe Interruption (e.g., staff illness, other issue)	1	3	3	Prioritize scope elements. Cross-train staff in each other's initiatives. Be prepared to de-scope lower priority elements if needed.
	Staffing				
15	Staff departures – Project Director	2	3	6	Our Project Director has made a commitment to the state to the end of the grant period. While she is playing a significant role in engaging stakeholders and facilitating the work of the SIM Steering Committee, the structure of the project means that she has back-up from other SIM-specific staff and colleagues throughout SIM participating agencies. We are also cross-training staff in the Director's initiatives.
16	Staff departures – Other Staff	3	3	9	As noted above, we are confident that our broad staffing structure and culture of sharing information would make a staff departure manageable from a risk perspective. Additionally, within our team (and noted in our timeline), staff have been paired up for many of the SIM-related activities to ensure coverage in the event a staff member departs the team and/or has a personal emergency and may not be available during critical implementation times.

C. General SIM Operational and Policy Areas

This section of the SIM Operational Plan document describes core operational components of the SIM Test Grant and discusses their alignment with the Integrated Population Health Plan. Discussion items include but not limited to governance, stakeholder engagement, healthcare transformation, payment delivery models, and regulatory authorities. Also included are cross-cutting topics such as measure alignment, workforce development, health information technology, and evaluation.

SIM Governance

Governance and Management Structure

SIM Project Leadership

Rhode Island SIM is at heart a public/private partnership, as well as an interagency collaboration. Therefore, its governance structure and decision-making authority is shared among a coordinated group of people and agencies, managed by SIM Project Director Marti Rosenberg. Ms. Rosenberg was hired in October, 2015. Her office sits at the Office of the Health Insurance Commissioner, and she reports to both Commissioner Kathleen C Hittner, and EOHHS Secretary Elizabeth H. Roberts.

Ms. Rosenberg leads a staff team made up of individuals hired with SIM dollars and placed at our member agencies. These staff members officially report to other staff members at the agencies, but they come together in a team that meets weekly and works together on all SIM projects. The attached SIM Organizational Chart depicts the SIM staffing structure including SIM designated and other state staff who support SIM efforts and the UMass Medical School project management team.

The next level of SIM activity takes place within our SIM's Interagency Planning Team, facilitated by Ms. Rosenberg. The Interagency team includes staff at various levels from all SIM participating state departments, plus our Steering Committee Chair, Lou Giancola. Mr. Giancola is the President and CEO of South County Health, which includes South County Hospital. The SIM Interagency Planning Team is responsible for the strategic implementation of the project: financial and planning oversight, organizing SIM goals and deliverables, overseeing stakeholder engagement, and tracking metrics.

While regulatory promulgation and procurement issues will continue to rest with the state government, the SIM Steering Committee is the public/private governing body for Rhode Island's SIM project. The committee's primary function is to set strategic direction, create policy goals, approve the funding plan, and provide oversight over the implementation of the SIM grant. The committee meets monthly and is comprised of community stakeholders who represent health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations. We understand that resting SIM decision-making in this public/private Steering Committee is unique in the country.

Another way that we benefit from the public/private partnership nature of SIM is through our Workgroups. The workgroups allow us to garner subject-matter expertise, receive stakeholder and community input, and secure implementation recommendations for SIM's transformation efforts. The Steering Committee has approved four specific SIM workgroups around our key test components to date and may request additional workgroups as necessary. Current workgroups include the following:

- **Integrated Population Health Plan** – providing subject-matter expertise and strategic oversight of the creation of Rhode Island's Integrated Population Health Plan and alignment of measures across the physical, behavioral, and overall health care continuum. Part of this work may include identification of measurement gaps that can be addressed through SIM via measure alignment, data analytics, regulatory levers and/or technology reporting. An example of this would be better collection of socio-

demographic data such as race/ethnicity to improve the ability to look at population health disparities. Similarly, some data sources that are self-report are limited due to funding to get a large sample size to report similar information within the aforementioned example on a lower-geo-scale (e.g., health equity zone or CHT level).

- **Measure Alignment** – providing subject matter expertise for the creation of Rhode Island's aligned measure set. Eventually this will transform into the governance committee for the measure set, responsible for an annual review and updates to the set.
- **Patient Engagement** – assisting with an inventory of current patient engagement activities taking place in Rhode Island and providing recommendations for filling patient engagement gaps.
- **Technology Reporting** – providing subject matter expertise on the creation and implementation of Rhode Island's Healthcare Feedback System and potentially other IT-related SIM projects.

To guard against duplicative meetings and extra work for the SIM staff, SIM is participating with two existing community groups to further our work with Community Health Teams and Provider Practice Transformation. These community workgroups have generously invited SIM to be a regular part of their agendas and allow us to consult with the experts sitting around their tables. Additionally, SIM has been invited to participate in the Commission for Health Advocacy and Equity, a group of policy-makers from various state entities. This group may be an extension for overarching alignment, vetting of new regulatory lever ideas, and integration activities. Lastly, analytic staff across EOHHS and its sister agencies gather monthly to coordinate their data and analytic priorities and combine knowledge on shared populations. The group has approximately 20 participants and is building one of its first projects: a dashboard to measure the well-being of adolescents across our agencies. The goal is to provide actionable surveillance information to agency and government directors to give holistic direction to their policy decisions.

Governor's Office Engagement in SIM

In February 2013 Rhode Island was awarded a CMMI State Innovation Model Design Grant to develop a State Health Care Innovation Plan (SHIP). The then Lt. Governor Elizabeth H. Roberts led the project known as Healthy Rhode Island, engaging multiple stakeholders to review current state payment and delivery system reform initiatives; identify data sources and baseline data for outcomes measures and financial analysis; and identify available and needed policy lever changes. The resulting SHIP document defined the strategy and mechanisms for moving Rhode Island's health care delivery system to a value-driven, community-based, and patient centered system.

With a change in administration in January, 2015, Rhode Island's new Governor Gina M. Raimondo appointed Ms. Roberts as Secretary of the Executive Office of Health and Human Services (EOHHS) where she continues to champion the SIM effort in Rhode Island.

Governor Raimondo's office retains a strong connection to the project with representation on the SIM Interagency Planning Team, the SIM Steering Committee, and the ability to attend SIM workgroups. The SIM Project Director engages in bi-weekly updates with Governor's Office staff to keep the administration aware of SIM activities and ensure coordination of efforts across all state healthcare innovation efforts.

Coordination of Private and Public Efforts

The administration has launched additional initiatives that align with SIM efforts. In February 2015 Governor Raimondo signed an executive order creating the Working Group to Reinvent

Medicaid which subsequently developed a plan both to improve the quality of care and to reduce costs for Rhode Island taxpayers. Then, building on the successful and ongoing efforts to make positive changes in the Medicaid program, the Governor assembled a group of 41 stakeholders – providers, insurers, advocates, businesspeople, and legislators – called the Workgroup Group for Healthcare Innovation. Governor Raimondo wrote an executive order charging the workgroup to propose solutions to spark innovation across healthcare and achieve healthcare's "Triple Aim" of improved health, enhanced patient experience, and reduced per-capita costs. In December 2015 the group unveiled a plan for a global health spending target, value-based payment reform, access to care, health information technology, population health goals, and opportunities to reduce waste and overcapacity. The Governor's office is continuing to determine how to implement this plan, and is communicating with SIM staff to promote alignment.

Regulatory Authority

Our SIM leaders understand that one of the key tools that we have to implement our transformation agenda are the regulatory levers that each participating state agency holds. Examples of these levers are OHIC's rate review responsibilities, and their Affordability Standards regulations. The Department of Health is responsible for licensing hospitals and healthcare providers, and issuing Certificates of Need. Our specific plan for using regulatory levers to meet our transformation goals is included in the Leveraging Regulatory Authority section of this plan.

Staffing Roles and Responsibilities

Our SIM teams work together efficiently, with clearly defined responsibilities, managed by Project Director Marti Rosenberg. Each of our SIM-funded staff people were hired with specific job descriptions laying out the work that they would do in their individual departments and thus, the expertise and relationships they bring to the staff and interagency teams.
The following chart details how our staff roles and responsibilities are generally divided:

Table 8: Staffing Roles and Responsibilities

Agency	Staff Title	Roles and Responsibilities
SIM	SIM Project Director	Oversee the implementation of the SIM grant, managing the staff and interagency teams, and staffing the Steering Committee. Oversee the procurement of the SIM transformation agenda, as well as the vendors hired to carry out the funded activities. Serve as the SIM liaison to the Governor's office, agency directors, and other state health leaders, and SIM's federal program officers and technical assistance providers. In this leadership role, guide the Multi-Sector/Multi-Agency alignment approach.
Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)	SIM Project Manager	Represent BHDDH on Interagency Team. Link behavioral health to physical health change components and serve as BHDDH lead on Integrated Population Health plan. Oversee behavioral health transformation elements, including managing procurement and implementation of projects such as Community Mental Health Center Provider Coaching, Child Psychiatry Access Project, and SBIRT. Carry out tasks as team member on BHDDH's CCBHC effort which aligns with state's value-based purchasing goals.

Agency	Staff Title	Roles and Responsibilities
Executive Office of Health and Human Services	HIT Specialist	Represent the HIT division of EOHHS on the Interagency Team. Provide oversight to the implementation of the technology components of our transformation agenda, Ensure that technology information and data are available to SIM workgroups, to weave in our HIT activities throughout all transformation work.
Health	Chief Health Program Evaluator	Represent RIDOH on the Interagency Team. Oversee the creation and implementation of the Integrated Population Health plan, ensuring alignment with the behavioral health components of our transformation agenda. Participate in the implementation of our Community Health Team project. Assist with evaluation activities.
HealthSource RI	Value-Based Purchasing Analyst	Represent HealthSource RI on the Interagency Team. Work with commercial carriers, Medicaid, and others to help guide the design of insurance plans, both QHP and Medicaid Managed Care, in support of value-based care and our transformation agenda. Also, lead HealthSource RI in reviewing and analyzing plan filings, and support the exchanges implementation of approved plans. Advise EOHHS efforts to develop models for value based purchasing in Medicaid.
Office of the Health Insurance Commissioner	Principal Policy Associate	Represent OHIC on the Interagency Team. Provide subject matter expertise and technical assistance to the SIM team on value-based purchasing, alternative payments models, and the regulatory activity needed to achieve our transformation goals. Provide technical expertise on practice transformation for health system reforms, including how our funded activities and uses of regulatory levers will help us reach our overall system change goals.

Figure 2 shows a detailed organizational chart of SIM project staff and is followed by a detailed table describing the roles of each individual.

Similarly, all Requests for Proposals (RFPs) include detailed Scopes of Work which make clear the roles and responsibilities expected of vendors. The chart below describes the major responsibilities of our current SIM vendors:

Table 9: Vendor Roles and Responsibilities

Vendor	Roles and Responsibilities
University of Massachusetts Medical School	Provide project management and oversight to sub-contractors who are carrying out the writing and research of the Integrated Population Health Plan and the facilitation of the Measure Alignment process
Freedman Healthcare, OnPoint Health Data, and 3M Healthcare	This team of vendors has managed the creation and programming of HealthFacts RI, our all payer claims database. Freedman provides project management, OnPoint is our data aggregator, and 3M is our data analyst.
Rhode Island Quality Institute	This nonprofit organization is Rhode Island's designated health information exchange. They have created and managed our Statewide Common Provider Directory.

Figure 4: SIM Project Staffing Organizational Chart

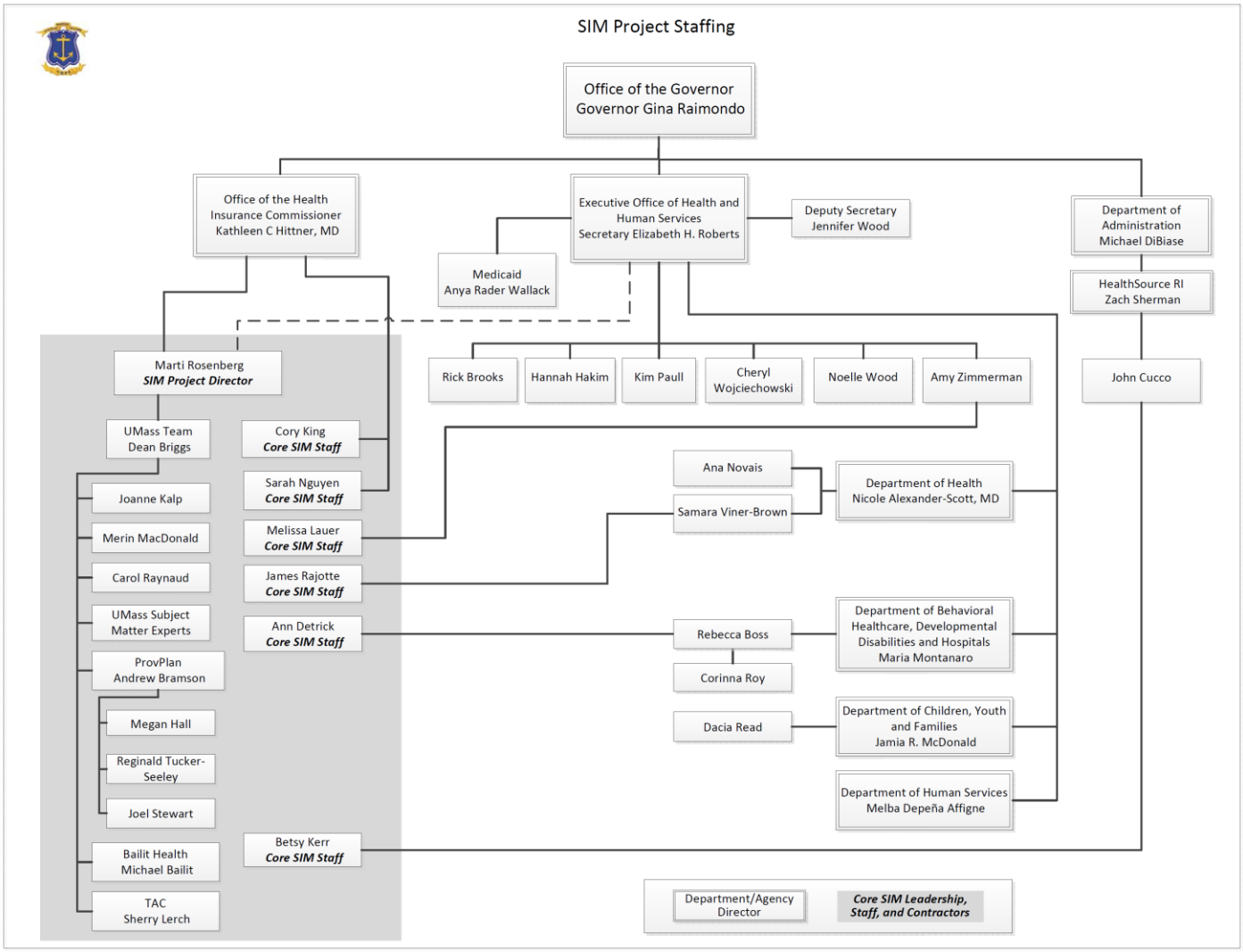


Table 10: SIM Project Staffing

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	**Component/Project Lead**		**Contact Information**	
	Position/Title	**Name**	**Phone Number**	**Email Address**
SIM Dedicated Staff				
SIM Director	SIM Project Director	Marti Rosenberg	401-462-9659	Marti.Rosenberg@ohic.ri.gov
Department of Behavioral Healthcare Developmental Disabilities and Hospitals	Chief of Transformation	Ann Detrick	401-462-3542	Ann.Detrick@bhddh.ri.gov
Department of Health	Chief Health Program Evaluator	James Rajotte	401-222-5142	James.Rajotte@health.ri.gov

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
Executive Office of Health and Human Services	HIT Specialist	Melissa Lauer	401-462-6485	Melissa.Lauer@health.ri.gov
HealthSource RI	Value-Based Purchasing Analyst	Betsy Kerr	401-462-3598	Betsy.Kerr@exchange.ri.gov
Office of the Health Insurance Commissioner	Principal Policy Associate	Cory King	401-462-9658	Cory.King@ohic.ri.gov
Office of the Health Insurance Commissioner	Principal Policy Associate	Sarah Nguyen	401-462-9643	Sarah.Nguyen@ohic.ri.gov
SIM Workgroups				
Integrated Population Health Workgroup	Lead staff	Ann Detrick James Rajotte	401-462-3542 401-222-5142	Ann.Detrick@bhddh.ri.gov James.Rajotte@health.ri.gov
Measure Alignment Workgroup	Lead staff	Cory King	401-462-9658	Cory.King@ohic.ri.gov
Patient Engagement Workgroup	Chair	Jim Berson		JBerson@gpymca.org
Technology Workgroup	Lead Staff	Melissa Lauer Amy Zimmerman	401-462-6485 401-462-1730	Melissa.Lauer@health.ri.gov Amy.Zimmerman@ohhs.ri.gov
SIM Steering Committee Members				
SIM Steering Committee	**Committee Chair**, representing South County Health	Lou Giancola	401-788-1602	LGiancola@schospital.com
SIM Steering Committee	Member, representing Lifespan	Mark Adelman		MAdelman@lifespan.org
SIM Steering Committee	Member, Director RI Department of Health	Nicole Alexander-Scott, MD	401-222-2232	Nicole.AlexanderScott@health.ri.gov
SIM Steering Committee	Member, Deputy Chief of	Eric Beane	401-222-8147	Eric.Beane@governor.ri.gov

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
	Staff Office of the Governor			
SIM Steering Committee	Member, representing Greater Providence YMCA	Jim Berson		JBerson@gpymca.org
SIM Steering Committee	Member, representing Tufts Health Plan	David Brumley		David_Brumley@tufts-health.com
SIM Steering Committee	Member, representing RI Kids Count	Elizabeth Burke Bryant		Ebb@rikidscount.org;
SIM Steering Committee	Member, representing Rhode Island Business Group on Health	Al Charbonneau		AlCharbonneau@verizon.net
SIM Steering Committee	Member, Director RI Department of Human Service	Melba Depena	401-462-0632	Melba.Depena@dhs.ri.gov
SIM Steering Committee	Member, representing Prospect Medical Holdings	Christopher Dooley		Christopher.Dooley@chartercare.org
SIM Steering Committee	Member, representing RI Primary Care Physicians Corp	Andrea Galgay		AGalgay@ripcpc.com
SIM Steering Committee	Member, representing UnitedHealthcare of New England	Neil Galinko		NGalinko@uhc.com
SIM Steering Committee	Member, representing RI Health Care Association	Jane Hayward		JHayward@RIHCA.org;
SIM Steering Committee	Member, RI Health Insurance Commissioner	Kathleen Hittner, MD	401-462-9638	Kathleen.Hittner@ohic.ri.gov
SIM Steering Committee	Member, representing RI Medical Society	Peter Hollmann, MD		PHollmann@lifespan.org

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
SIM Steering Committee	Member, representing Care New England	Dennis Keefe		DKeefe@CareNE.org
SIM Steering Committee	Member, representing Coastal Medical	Alan Kurose, MD		GAKurose@coastalmedical.com
SIM Steering Committee	Member, representing CareLink	Joan Kwiatkowski		JKwiatkowski@carelink-ri.com
SIM Steering Committee	Member, representing Gateway Health Care	Richard Leclerc		RLeclerc@lifespan.org
SIM Steering Committee	Member, representing Blue Cross Blue Shield of RI	Gus Manocchia, MD		augustine.manocchia@bcbsri.org
SIM Steering Committee	Member, representing Neighborhood Health Plan of RI	Peter Marino		PMarino@nhpri.org
SIM Steering Committee	Member, Office of the Governor Policy Staff	Sam Marullo	401-222-2080	Sam.S.Marullo@governor.ri.gov
SIM Steering Committee	Member, Chief Strategy Officer RI Department of Children Youth & Families	Jamia McDonald	401-528-3540	Jamia.McDonald@ohhs.ri.gov
SIM Steering Committee	Member, Director RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Maria Montanaro	401-462-2339	Maria.Montanaro@bhddh.ri.gov
SIM Steering Committee	Member, Secretary Executive Office of Health and Human Services	Elizabeth H. Roberts	401-462-5274	Elizabeth.Roberts@ohhs.ri.gov

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
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SIM Steering Committee	Member, Director of HealthSource RI	Zachary Sherman	401-462-3592	Zachary.Sherman@exchange.ri.gov
SIM Steering Committee	Member, representing The Rhode Island Foundation	Neil Steinberg	401-274-4564	NSteinberg@rifoundation.org
SIM Steering Committee	Member, representing The Substance Use and Mental Health Leadership Council of RI	Susan Storti		SStorti@sumhlc.org
SIM Steering Committee	Member, Medicaid Director	Anya Rader Wallack	401-462-2488	Anya.Wallack@ohhs.ri.gov

Vendor Procurement

SIM has completed the hiring of all of our state staff members, following Rhode Island's strict hiring processes. This included posting the job announcements on the state procurement website, recruiting a hiring team, and completing one or more face-to-face interviews. We sought the assistance of SIM Steering Committee members and other community stakeholders to disseminate job postings throughout their professional networks, and the hiring committee for the Project Director included a number of community participants. Should we need to hire additional staff members throughout the project, we would continue to follow these rules.

Additional vendors will be engaged to fully implement Rhode Island's SIM Transformation activities, using the rigorous process required by the state purchasing office. All vendor procurement is managed by state staff (rather than vendors) and meetings are underway to develop Requests for Proposals according to state procurement procedures to solicit the remaining vendors.

Staff Training

As noted above, each designated SIM staff person was hired as a subject-matter expert and works within one of the SIM partner agencies. Each agency has provided orientation materials as appropriate for that agency and each staff member is supervised by appropriate agency staff. SIM staff participate in webinars such as SIM Learning Events and are encouraged to attend state and national conferences as appropriate to their area of expertise.

Evaluation and Continuous Quality Improvement

SIM has planned an overall project evaluation process with both internal and professional activities that is described in the Program Monitoring and Reporting section of this plan. However, the staff and interagency teams are committed to the concept of continuous quality improvement and thus carry out routine evaluations and debriefs on a regular basis to ensure that the project is on track. For example, following every Steering Committee meeting, the staff and interagency teams carry out a debrief conversation to evaluate how the meeting went and what follow-up is needed. Immediately following every public workgroup meeting on our Integrated Population Health Plan, we hold a meeting with all of the participating vendors to determine next steps.

Stakeholder Engagement

Rhode Island's Approach to Stakeholder Engagement

Rhode Island has traditionally valued the inclusion of the public and private stakeholders in efforts to transform our health care system. The Rhode Island State Innovation Model (SIM) Test Grant proposal is built on the intensive stakeholder engagement that was a hallmark of the State Health Innovation Plan creation that led to the SIM Model Design process. The Healthy Rhode Island Stakeholder Work Group consisted of nearly 150 stakeholders representing state government, payers, hospitals, physicians, long-term-care and behavioral health providers, community organizations, employers, the Narragansett Indian Tribe, and patient advocates.

The goals and objectives of our SIM effort will only be attained through a similarly robust, inclusive process. Rhode Island is relying on our experience in facilitating meaningful stakeholder engagement and an expansive and representative group of participants to meet the challenge of health system transformation. Under the Rhode Island SIM Test Grant, Rhode Island is continuing in that tradition and implementing this grant in an open and transparent manner. Rhode Island is pursuing the implementation with active collaboration within state government and in explicit partnership with external public and private sector entities.

The success of Rhode Island's SIM Test Grant rests on our ability to implement three foundational changes in state government: improved internal alignment, explicit external partnerships, and effective use of information technology. In order to achieve these changes and meet the objectives of the grant, Rhode Island must have engaged key stakeholders representing state government, community organizations, payers, and providers.

Description of Stakeholders

Stakeholders were originally organized into three working groups:

- SIM Core Staff Team;
- SIM State Working Group; and
- SIM Steering Committee.

SIM Core Staff Team

The Core State Team met weekly February through April 2015 and was comprised of heads of staff from the Executive Office of Health and Human Services (EOHHS) and the Office of the Health Insurance Commissioner (OHIC). This team, headed by the acting SIM project director, was responsible for interfacing with the Center for Medicare and Medicaid Innovation (CMMI) and organizing the goals and deliverables of the SIM State Working Group, including development of project materials.

SIM State Working Group

The SIM State Working Group also met on a weekly basis during this time period and was comprised of additional EOHHS and OHIC staff. This team was responsible for the implementation of the SIM Grant. The team's original charge was to:

- Pursue the goals related to improved coordination of regulatory, fiscal, and policy levers;
- Work with other entities to ensure state efforts on data collection, reporting, and analyses are integrated and not duplicative; and

- Lead the transformation of state health and human services agencies, operating in a well-coordinated, cost-effective, transparent environment that is focused on the people of Rhode Island and the improvement of the state's health care system.

SIM Steering Committee

The SIM Steering Committee held its first meeting on March 10, 2015 and has met monthly ever since (excluding a summer hiatus). This committee is the public/private governing body for the grant effort. It is charged with setting the strategic direction and policy goals. While regulatory promulgation and procurement issues will continue to rest with the state government, the Steering Committee exercises leadership discretion over the implementation of the SIM grant. The current Steering Committee is comprised of several members of the original Healthy Rhode Island Steering Committee (convened during the SIM Model Design process) who were actively engaged in the development of the SIM Grant and participated in the face-to-face interview for the SIM Test Grant proposal, and other community stakeholders.

Current Organization of Stakeholders

It became clear by May, 2015 that this structure needed to evolve to maximize our team's efficiency in implementing SIM grant deliverables. In May, 2015 the Core State Team and the SIM State Working Group were combined into the SIM Interagency Planning Team and has met weekly since then. This team is now led by Marti Rosenberg who was hired as SIM Project Director in October, 2015. More recently, we have established several SIM Steering Committee workgroups to operationalize the Rhode Island SIM Test Grant.

SIM Interagency Team

Weekly SIM Interagency Planning Team meetings are attended by department heads, SIM dedicated staff and other staff members from the following state departments: Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH); Children Youth, and Families (DCYF); Executive Office of Health and Human Services (EOHHS); Health; HealthSource RI, Human Services, (DHS), and the Office of the Health Insurance Commissioner (OHIC). This new team is responsible for the strategic implementation of the project: organizing SIM goals and deliverables, and tracking metrics.

Additional Workgroups

The SIM Steering Committee continues to meet monthly. This public/private group remains the governing body of group and is charged with setting the strategic direction and policy goals of the grant effort. The Steering Committee has commissioned four of our own Workgroups to provide subject-matter expertise, community input, and recommendations for action. The Steering Committee may request the establishment of more workgroups as necessary. Current workgroups include:

- Integrated Population Health Plan;
- Measure Alignment;
- Patient Empowerment; and
- Technology Reporting.

Community Group Engagement

As noted above, to avoid duplicative meetings and extra work for the SIM staff, SIM is participating with two existing community groups to further our work with Community Health

Teams and Provider Practice Transformation. SIM is a regular part of their agendas so that we may consult with the experts sitting around their tables.

Figure 5: SIM Functional Organizations

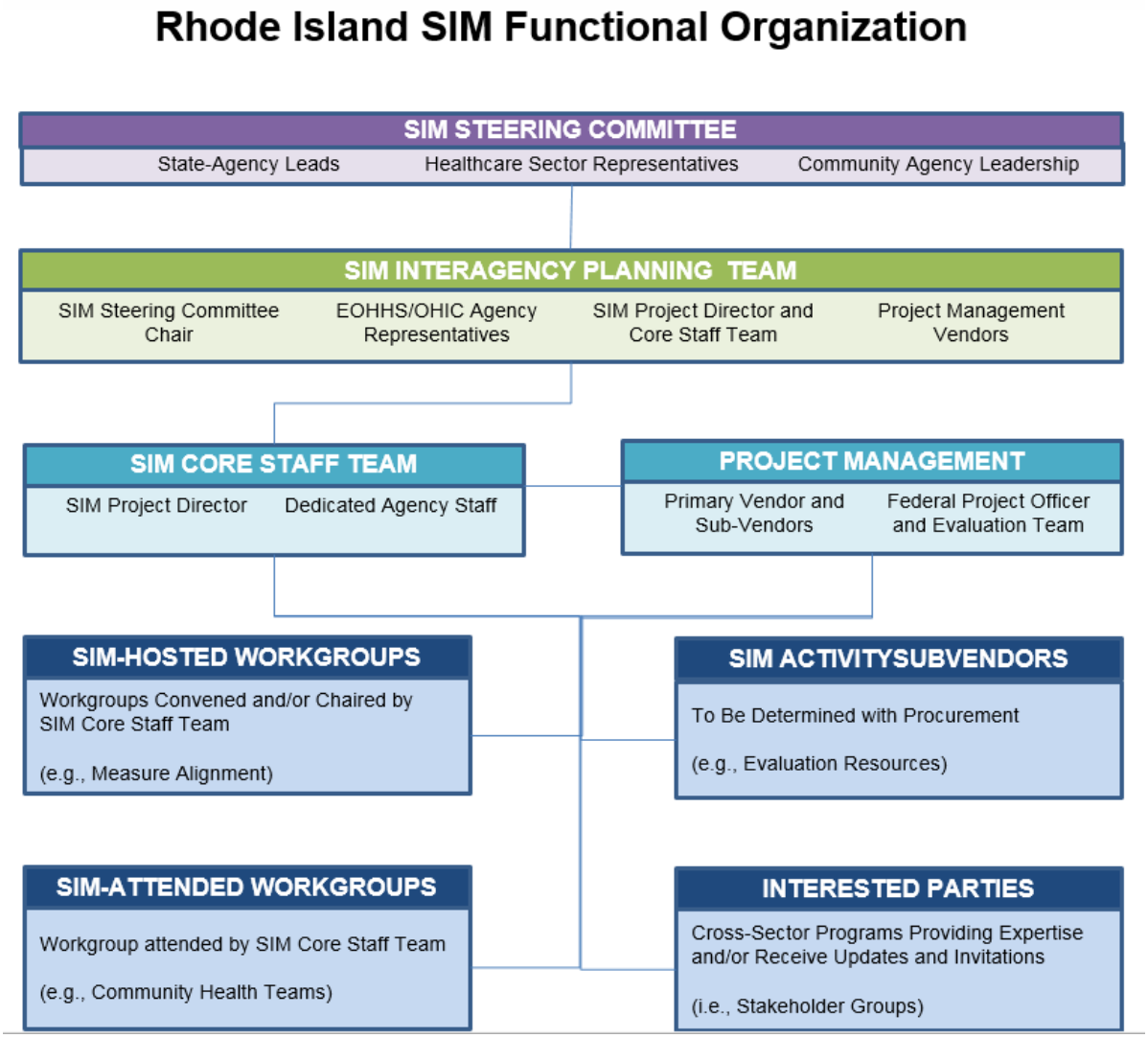
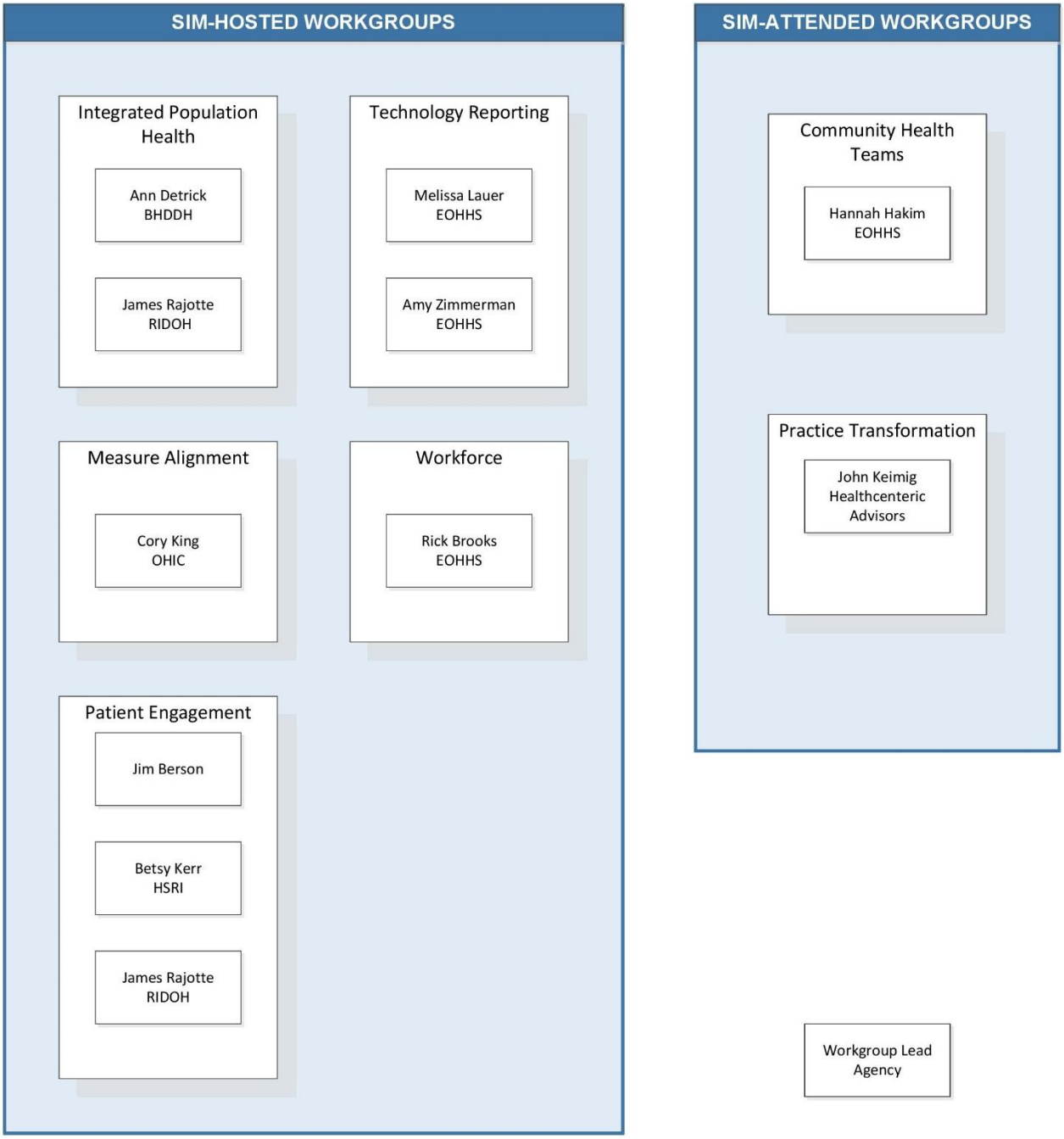


Figure 6: Rhode Island SIM Workgroups



Entities Represented as Stakeholders

Tables 10 and 11 illustrate that Rhode Island has established meaningful relationships with a significant number of key stakeholders who are representative of their populations. Representatives from healthcare providers and systems, commercial payers and purchasers, state hospital and medical associations, community-based and long term support providers, and

consumer advocacy organizations are engaged and actively committed to the implementation of the Rhode Island SIM Test Grant.

Stakeholders by Group

Table 10 lists stakeholder entities grouped into categories for each stakeholder group.

Stakeholders on Steering Committee

Table 11 lists each SIM Steering Committee stakeholder categories and their members, as well as the rationale for their engagement.

Table 11: Stakeholders by Group

	Medical Providers & Systems	Commercial Payers & Purchasers	State Hospital & Medical Associations	Community -based & Long Term Support Providers	Consumer Advocacy Organizations & Other Community Entities	State Government, Councils, Commissions, etc.
Interagency Planning Workgroup	Lou Giancola, CEO South County Health					EOHHS BHDDH DCYF DHS RIDOH HealthSource RI OHIC
SIM Steering Committee	Care New England Charter CARE Coastal Medical Lifespan RI Primary Care Physicians Corporation South County Health	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI Tufts Health Plan	RI Business Group on Health RI Council of Community Mental Health Organizations RI Health Center Association RI Medical Society	CareLink YMCA of Greater Providence	RI Kids Count RI Foundation	EOHHS BHDDH DCYF DHS RIDOH HealthSource RI OHIC Office of the Governor

		Medical Providers & Systems	Commercial Payers & Purchasers	State Hospital & Medical Associations	Community -based & Long Term Support Providers	Consumer Advocacy Organizations & Other Community Entities	State Government, Councils, Commissions, etc.
SIM Steering Committee Workgroups	**Patient Engagement**	Lifespan Care New England South County Health RI Primary Care Physicians Corporation The Providence Center UMass--CTC	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI Tufts Health Plan UnitedHealthcare of New England	RI Medical Society RI Health Center Association RI Business Group on Health	CareLink YMCA of Greater Providence	RI Kids Count RI Foundation RI Parent Information Network Right Question Institute National Academy for State Health Policy Healthcentric Advisors RI Quality institute RTI International	EOHHS BHDDH DCYF DHS RIDOH HealthSource RI OHIC Office of the Governor Dept Labor & Training State Council on the Arts Commission on the Deaf & Hard of Hearing
	Technology Reporting	University Medicine Prospect Medical Holdings UMass—CTC East Bay Community Action Program Comprehensive Community Action Program	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI UnitedHealthcare of New England	Hospital Association of RI		Healthcentric Advisors RI Kids Count RI Quality institute	EOHHS BHDDH

		Medical Providers & Systems	Commercial Payers & Purchasers	State Hospital & Medical Associations	Community -based & Long Term Support Providers	Consumer Advocacy Organizations & Other Community Entities	State Government, Councils, Commissions, etc.
	Measure Alignment	Lifespan Care New England Women & Infants Hospital University Medicine	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI UnitedHealthcare of New England Tufts	Hospital Association of RI RI Health Center Association RI Medical Society American Academy of Pediatrics RI	Brown University	RI Quality institute RI Parent Information Network	EOHHS BHDDH DCYF DHS RIDOH
	Integrated Population Health Plan	Gateway Health Horizon Healthcare Partners Integra Community Care Network PCMH-K Hasbro Children's Center Prospect Charter Care The Providence Center	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI	RI Academy of Pediatrics RI Business Group on Health RI Health Center Association RI Medical Society		RI Parent Information Network RI Quality institute	EOHHS RIDOH BHDDH

Table 12: Stakeholders on Steering Committee

Stakeholder Information	Background and Rationale for Engagement
Payers: Blue Cross Blue Shield RI Neighborhood Health Plan Tufts Health Plan UnitedHealthcare of NE	All of Rhode Island's major commercial and Medicaid managed care payers are involved in SIM. The perspective of leaders from the payer community ensures that we have a clear understanding of the implications of a transformed payment system for insurers and for their members. Our goal is to move forward in a consistent, coordinated fashion on projects such as implementing an aligned measure set, creating a shared technology and reporting feedback system, and addressing the social and environmental determinant of health through Community Health Teams as the state and the payers make changes toward a value-based healthcare system.

Stakeholder Information	Background and Rationale for Engagement
Providers (Hospitals): Care new England Charter CARE Lifespan South County Hospital	Hospital stakeholders bring valuable experience and lessons-learned to the table. The three Rhode Island hospital systems and the one independent hospital listed are all currently engaged some level of payment reform, forming partnerships and aligning with payers to design new payment reform models.
Providers (Physician Practices): Coastal Medical RI Primary Care Physicians Corporation (RIPCPC)	Coastal Medical is Rhode Island's largest, Private Group Practice, a Medicare Shared Savings Program Accountable Care Organization (ACO), and a Patient Centered Medical Home. Coastal physicians care for over 105,000 patients across Rhode Island and Massachusetts. RIPCPC is an independent practice association (IPA) that was formed to provide a venue for smaller independent practices to work together with the ultimate goal of improving quality of care for their patients. RIPCPC's PCPs care for over 340,000 patients throughout the state. Both groups bring experience with working with hospitals on new payment models.
Providers (other): CareLink	CareLink is a nonprofit management service organization that provides key strategic business activities to its members who serve older adults and adults with disabilities, and consultation services to other health care providers. CareLink brings their experience with long-term care service models.
Community Entities: RI Business Group on Health Rhode Island Foundation Rhode Island Health Center Association RI Kids Count Rhode Island Medical Society Substance Use and Mental Health Leadership Council YMCA of Greater Providence	Each community entity represents their members on the Steering Committee, bringing to the body information about the impact of a transformed health care system on their membership, how the changes will improve population health and patient care for their membership, and thinking together about how the changes could reduce the cost of health care. We are asking members to assist with evaluating the risks and benefits of change and the identification of barriers, drivers, and priorities to consider in developing the Integrated Population Health Plan with a focus on behavioral health transformation.
EOHHS – Executive Office of Health & Human Services	EOHHS is responsible for coordinating the organization, finance, and delivery of services and supports provided through BHDDH, DCYF, DHS, and RIDOH. It is administering the SIM grant for the state and it is also the single state Medicaid agency. EOHHS has the legal authority to amend Medicaid related statutes/regulations related to payment reform and service delivery.
RIDOH – Department of Health	RIDOH is the state agency specifically responsible for preventing disease and protecting and promoting the health and safety of the people of Rhode Island. RIDOH's regulatory authority includes the ability to collect and track data for population health purposes, along with setting minimum standards of operations for 26 types of healthcare facilities, setting minimum qualifications and standards of care for 35 health-related professions, setting licensing fees for health professionals, and influencing prescribing behavior. Within this broad-based authority, RIDOH has opportunities to develop and implement a population health plan as well as promulgate regulations in support of the Value-Based Care Paradigm.

Stakeholder Information	Background and Rationale for Engagement
BHDDH – Department of Behavioral Health, Developmental Disabilities, and Hospitals	BHDDH administers a comprehensive system of care for people with mental illness, physical illness, developmental disabilities, and substance use disorders, and administers a coordinated system of mental health promotion and substance abuse prevention. BHDDH is the State Mental Health Authority, the State Substance Abuse Authority, the licensing body of Behavioral Healthcare Organizations, an administrator of funding, and has the authority to propose, review, and/or approve proposals, policies or plans involving insurance and managed care systems for mental health and substance abuse services. BHDDH is a critical partner within SIM in carrying out a Behavioral Health Transformation plan as part of the Integrated Population Health Plan.
DCYF – Department of Children, Youth, and Families	DCYF was not part of the original list of state government stakeholders but has been added since the implementation of the grant in recognition of the role the agency plays in the health and well-being of children and specifically in its role as the children's behavioral health authority. DCYF works closely with other state agencies including BHDDH and RIDOH to focus on improvements in child behavioral health, ensuring strong coordination of care for children in foster care. DCYF works with Medicaid in particular around children's health care needs as they transition out of state care. DCYF's work with SIM will inform the identification of barriers, drivers, and priorities to consider for children's behavioral health as we develop and implement the Integrated Population Health Plan with a focus on behavioral health transformation.
DHS – Department of Human Services	DHS was not part of the original list of State government stakeholders but has been added since the implementation of the grant in recognition of the role the agency plays in the provision of services that are integral to health and well-being, including access to food, child care, and income assistance. DHS services benefit families, adults, children, elders, individuals with disabilities and veterans. DHS's role is to assist with evaluating the risks and benefits of change and the identification of barriers, drivers, and priorities to consider in developing the Integrated Population Health Plan with a focus on behavioral health transformation.
OHIC –Office of the Health Insurance Commissioner	Rhode Island is the only state in the country with a health insurance commissioner. OHIC exercises prior approval rate and form review authority for individual, small group, and large group insurance markets. As of April 2014, these markets comprised 234,000 members (206,000 of whom are RI residents). OHIC revised its Affordability Standards in February 2015 to establish measurable standards for insurers to promote system-wide affordability of coverage and strategic investment in primary care infrastructure. SIM is using these standards to help further the principles of the Value-Based Care Paradigm.
DOA – Department of Administration a. HealthSource RI b. State Employee Health Care	DOA administers the State Employee Health Plan, covering over 35,000 Rhode Islanders between employees, dependents and retirees. DOA is currently exploring the development of an alternative health plan offering that includes a focus on health improvement through the use of value based networks and plan design. DOA also houses HealthSource RI, the state-based insurance market place that supports the Value-based Care Paradigm by working with health insurers to develop and promote health insurance plans focused on providing better care. Specifically, HealthSource RI has worked with health insurers on new plans with limited, integrated networks that incorporate an emphasis on patient-centered care and alternatives to traditional fee-for-service reimbursements.

Strategy for Maintaining Stakeholder Commitment

The Rhode Island SIM Test Grant is committed to the public/private partnership that is the hallmark of our structure and process. While it may be possible for state government to work alone to transform our health care system by amending statutes and imposing new regulations on payers and providers, the participation of stakeholders is fundamental to achieving a coordinated transformation, ensuring community consensus and achieving our goals of supporting better patient care, improving population health, and reducing the cost of health care. Community organizations bring a clear understanding of the risks and benefits, barriers and drivers, and overall impact of a transformed health care system on their constituents. Payers bring a wealth of information about the implications of a transformed payment system on the insurance market and the health care system. The participation of providers, both hospitals and physician groups, is needed to share an assessment of the work they have already begun in developing alternative payment models, and the impact of these changes on Rhode Island's healthcare workforce.

What makes the Rhode Island SIM Test Grant unique among SIM-recipient states is the extent to which our public/private partnership has decision-making authority over the entire grant spending priorities. Though EOHHS is responsible for coordinating the organization, finance, and delivery of services and supports provided through state agencies, the steering committee is the driving force behind Rhode Island SIM Test Grant activities including defining stakeholder outputs and deliverables. This level of engagement from the private sector in implementing a federal grant is new and notable. These private sector organizations are in true partnership with the state, determining how Rhode Island SIM Test Grant funds will have an impact on the overall health system of Rhode Island–not just helping in an advisory capacity. The Steering Committee also assisted in the hiring of the Rhode Island SIM Project Director and, as the law allows, into the strategic thinking behind the procurement of our transformation activities.

Each organization on the SIM Steering Committee has identified an individual to provide guidance and subject matter expertise to the committee. This person is expected to participate for the full four-year grant period – and if he or she is unavailable for a meeting, is expected to ensure that an organizational representative attends in their absence. Each stakeholder may also be asked to participate in a workgroup to be established as required by the Steering Committee (See Table 1). Each stakeholder organization is also expected to facilitate the transformation of the health care system and the work of the Steering Committee as it relates to their organizations and the community at large. They are also expected to assure coordination between their organization and the Steering Committee.

The Steering Committee meets monthly (excluding a summer hiatus). All meetings are subject to the state's statutory open meeting requirements, through the Secretary of State's website. Steering Committee agendas, minutes, and supporting documents are also posted on the EOHHS Rhode Island website. Members of the public are welcome and are given the opportunity to provide comment at every meeting.

The dual role of the Steering Committee chair is an integral component of our method for stakeholder engagement. The Chairperson is also an active participant of the SIM Interagency Planning team, attending weekly meetings and monthly planning sessions with the EOHHS Secretary and the Health Insurance Commissioner. This dual role provides a direct communication link between the two groups and ensures stakeholder input into all SIM Test Grant activities. Louis Giancola, CEO of South County Health, has served as Steering Committee Chair since in the inception of the committee. His energy and input has been integral to

ensuring open communication between the two groups and helping to develop the state's system transformation implementation.

Marti Rosenberg, SIM Project Director works with partner agencies to lead and coordinate the accomplishment of grant deliverables. Key functions of this position related to stakeholder engagement include:

- Supporting and facilitating Steering Committee operations[
- Coordinating the development and preparation of all materials to support the deliberations of the Steering Committee;
- Presentation of subject matter information and data to Steering Committee;
- Convening and coordinating the work of the SIM Interagency Planning Team; and
- Establishing and maintaining relationships within partner state agencies, with community stakeholders, and workgroups to successfully accomplish project objectives.

Besides the organizations officially on the Steering Committee, SIM works with several critical partners that have been engaged in transformative work for many years. These include the Rhode Island Quality Institute (the state's Regional Health Information Organization), Healthcentric Advisors (the state's quality improvement organization), and the Care Transformation Collaborative of Rhode Island (a patient-centered medical home initiative), as well as other organizations. Due to their clear commitment and their past, present, and future efforts to transform health care, they are actively engaged in SIM implementation as members of Workgroups, but because it was recognized that they are likely to be contractors at some point in the process, they were not officially appointed to the Steering Committee.

Similarly, SIM engages with other stakeholders who are not official Steering Committee members, such as leaders of community action agencies, advocacy groups, and other interested parties. Much of the outreach at this level is conducted through Steering Committee workgroups as identified in Table 10. We are also planning public forums throughout the state, where members of the public can contribute and react to our Integrated Population Health Plan.

Under the direction of Governor Raimondo, there are two other large public health reform efforts that have been taking place over the past year which coordinate with SIM. First, the state began a re-design of the Medicaid Program[2] in 2015. The Governor appointed a diverse group of health care professionals, patient advocates, businesspeople and other policy leaders to address the structural challenges facing Rhode Island's Medicaid system. The effort is now being implemented, and informs Rhode Island's SIM activities.

Second, the Governor created the Working Group for Healthcare Innovation to provide recommendations regarding a global health spending cap for Rhode Island, to support the SIM goals of tying 80% of healthcare payments to quality by 2018, developing a next-generation health information technology system for all payers, and establishing performance management frameworks to achieve population health and wellness goals. The Workgroup has issued its first report, and SIM is prepared to continue working with the group as it moves forward.

Rhode Island has a strong history of community-based engagement in our healthcare system. SIM's structure, process, goals, and planned strategies all flow from that history and commitment to the idea that it will take all of us working together to create the healthcare system that will improve population health, improve healthcare, and hold down costs.

[2] http://reinventingmedicaid.ri.gov/

Integrated Population Health Plan

The Rhode Island State Innovation Model (SIM) Integrated Population Health Plan (IPHP) fulfills the requirements for the Centers for Medicaid and Medicare Services (CMS) SIM Test Grant. This version of the SIM IPHP supersedes any previous version of the plan. This plan demonstrates the alignment of efforts within the state to integrate healthcare transformation within overall integrated population health planning. This IPHP serves two purposes. First, the population health plan describes the health of Rhode Islanders and the current landscape of population health improvement efforts. Secondly, the plan provides frameworks, strategies, and goals for population health improvement, ensuring overarching alignment and sustainability of current and planned efforts.

Overview

Rhode Island aims to achieve measurable improvement in the health and productivity of all Rhode Islanders. In order to make this desired improvement a reality, the healthcare delivery, public health, behavioral health, community development, and social service sectors must work together and collaborate with the many academic, public, and private institutions within the state to ensure that all Rhode Islanders are able to achieve their highest health potential, regardless of who they are or where they live. In order to remove the systemic and structural barriers within the healthcare delivery system that can inhibit population health improvement, a multi-sector and multi-agency approach that will helps Rhode Island transition from an uncoordinated, provider- and payer-centric care environment into a well-coordinated and integrated health system, which will allow for the removal of systemic and structural barriers within the healthcare delivery system that can inhibit population health improvement is needed. In this new system, not only are public health, behavioral health, social service, and healthcare delivery systems efficiently coordinating person-centric care, these systems are continuously improving the quality of services, reducing the cost of care and focusing on improved population health outcomes.

Defining Population Health

Rhode Island's approach to improving population health includes efforts to address health needs across the lifespan, from birth to death. Our approach also commits to viewing health from the perspective of the "whole-person," including a focus on both the mind and the body. In Rhode Island, whenever we say "population health," we mean physical and behavioral health. When we say "behavioral health," we also mean mental health and substance use. In Rhode Island, we agree that physical health and behavioral health are "everyone's business," founded on a common understanding that behavioral health and well-being play a critical role in creating a healthy, resilient, and productive community.

- Health is not merely the absence of disease, but the state of complete physical, mental, and social well-being, including the "ability to adapt and to self-manage in the face of social, physical and emotional challenges."[3] Health is considered a resource for everyday life and is created where we live, learn, work, and play. Population health, specifically,

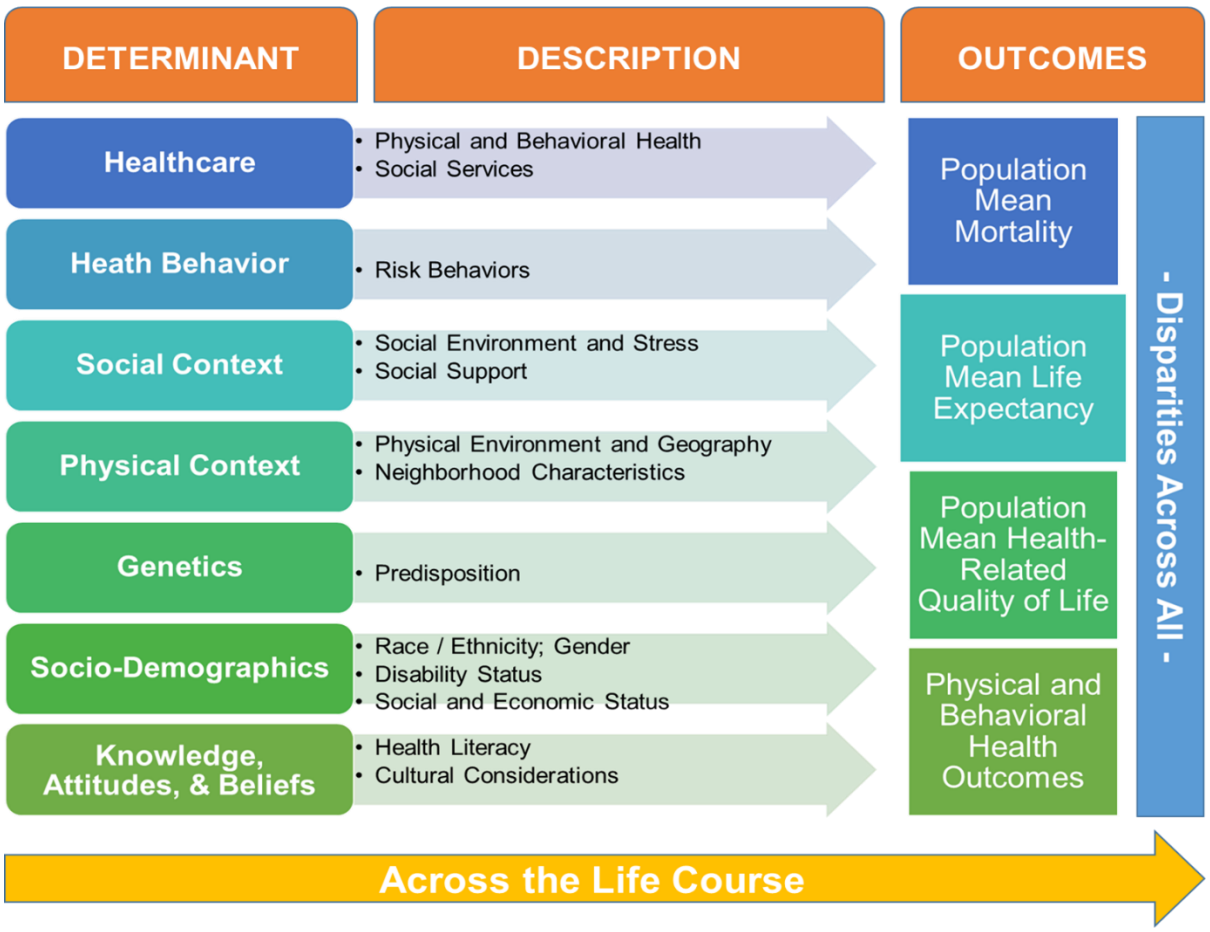
[3] Huber, M., Vliet, M. V., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P. C., & Knottnerus, J. A. (2016). Towards a 'patient-centred' operationalisation of the new dynamic concept of health: a mixed methods study. *BMJ Open,* 6(1). doi: 10.1136/bmjopen-2015-010091

refers to the aggregation of health outcomes of a group of individuals selected based on a specific characteristics (e.g., geography, care setting, and health status) and includes the distribution of such outcomes within and across groups.[4] Many factors that impede an individual's ability to achieve optimal health or to obtain the healthcare needed have been identified. Throughout the life course these factors may gradually accumulate through exposures to adverse environmental and social conditions, behaviors that increase disease risk, and episodes of illness.[5]

When defining population health, we must focus on the various determinants of the health in resulting health outcomes across the lifespan continuum cannot be overlooked. Population health planning must consider multi-factor, developmental, and life course perspectives that recognize the critical importance of early life and childhood experiences, the accumulation of exposures across the lifetime, and person-context interactions. The figure below depicts the conceptual model of population health using a determinant and life course frame.

Figure 7

Proposed Model of Population Health



Adapted from Bharmal, N. et al. (2015)

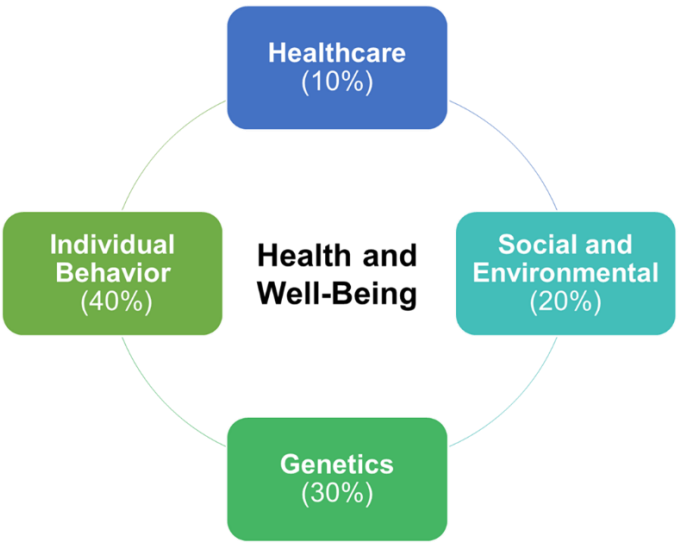
[4] Kindig, D. A. (2007). Understanding Population Health Terminology. *Milbank Quarterly,* 85(1), 139-61. doi: 10.1111/j.1468-0009.2007.00479.x.
[5] Kuh, D., & Ben-Shlomo, Y. (2004). Introduction: A life course approach to the aetiology of adult chronic disease. *A Life Course Approach to Chronic Disease Epidemiology,* 3-14. doi: 10.1093/acprof:oso/9780198578154.003.0001

Improving Population Health

Improving population health requires addressing a variety of the determinants of health, such as health behaviors, social and environmental contexts, and healthcare. Some determinants (e.g., genetics) cannot be addressed as directly as many of the other seven determinants listed in the figure above. In the figure below, it is estimated that approximately 10% of risk is due to healthcare when looking at premature death. In reality, approximately 60% of risk is attributed to social, behavioral, and environmental determinants.

Figure 8

Risk of Premature Death and Determining Factors



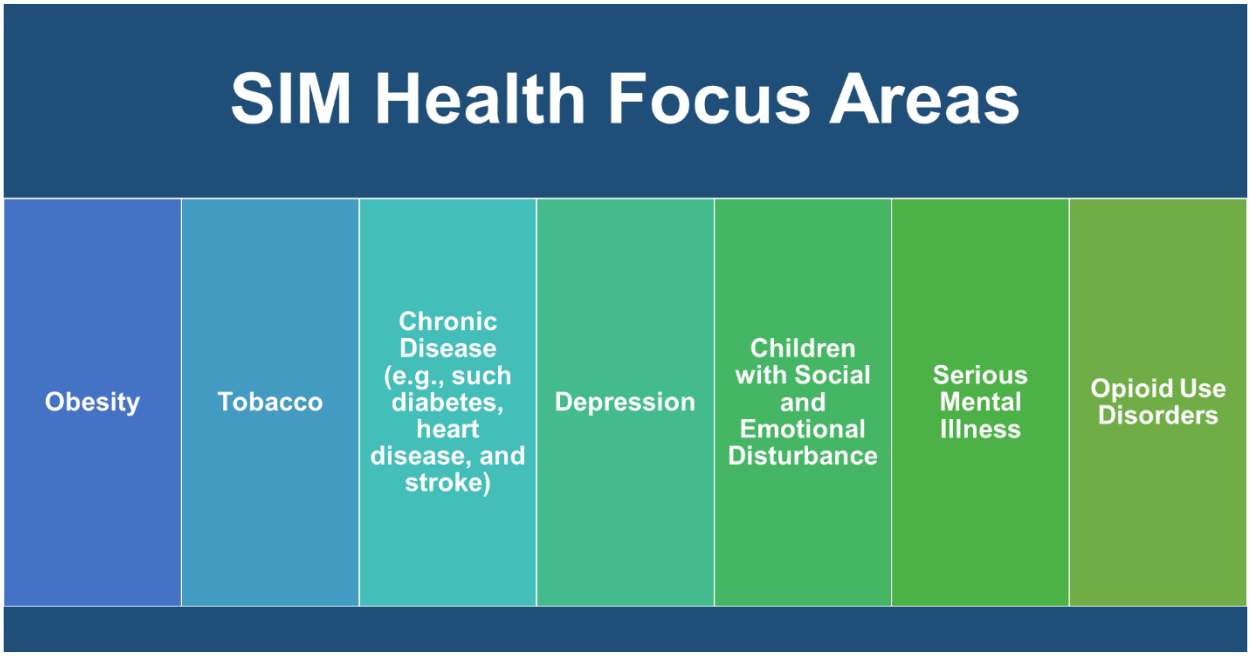
Adapted from Schroeder, SA. (2007).

Because healthcare as a determinant of health plays a potentially smaller role in population health outcomes than other determinants, we must transform healthcare in a way that increases access to quality services, extends into the community setting, and integrates physical and behavioral health. To compliment the transformation efforts supported by the Rhode Island SIM Test Grant, the IPHP development began with four health focus areas that most related to the SIM investments located within the Rhode Island SIM Transformation Wheel, including those areas where healthcare-driven outcome improvements are likely. The SIM grant requires that the IPHP identify opportunities to advance population health as part of the state's proposed health system transformation activities and to maximize the impact of various activities on population health, quality care, and healthcare costs.

Initially, the Interagency Planning Team identified four health focus areas: obesity; tobacco; chronic disease, such as diabetes, heart disease, and stroke; and behavioral health morbidity. Upon further analysis during development of the IPHP, it became apparent that behavioral health morbidity as a whole was too broad of a health focus area. Because of this, behavioral health morbidity was replaced with four core behavioral health issues facing Rhode Island. These additional health focus areas would also be addressed by the investments within the

Rhode Island SIM Transformation Wheel. The figure below depicts the final set of health focus areas.

Figure 9



Rhode Island State Innovation Model (2016).

These seven areas of focus represent the primary population health issues being addressed by the Rhode Island SIM Test Grant. While other health issues are likely to be addressed within the efforts of SIM, the main emphasis for alignment of interventions, policy, and measures remains on the seven focus areas. The intent is that the IPHP developed through the SIM process will continue beyond its submission with the SIM Operational Plan, becoming a living document expanding the health focus areas. Although the IPHP focuses on specific physical and behavioral health conditions or diseases, we aim to create an approach that centers on wellness, not disease. As the plan evolves, our strategies will move toward methods that help Rhode Islanders live long, productive and healthy lives, addressing them not just as patients but as people.

Integrating Physical and Behavioral Health

Providing high quality healthcare is the primary goal for the healthcare delivery system. However, the Rhode Island SIM Test Grant is also focused on additional objectives associated with the primary goal. These objectives include:

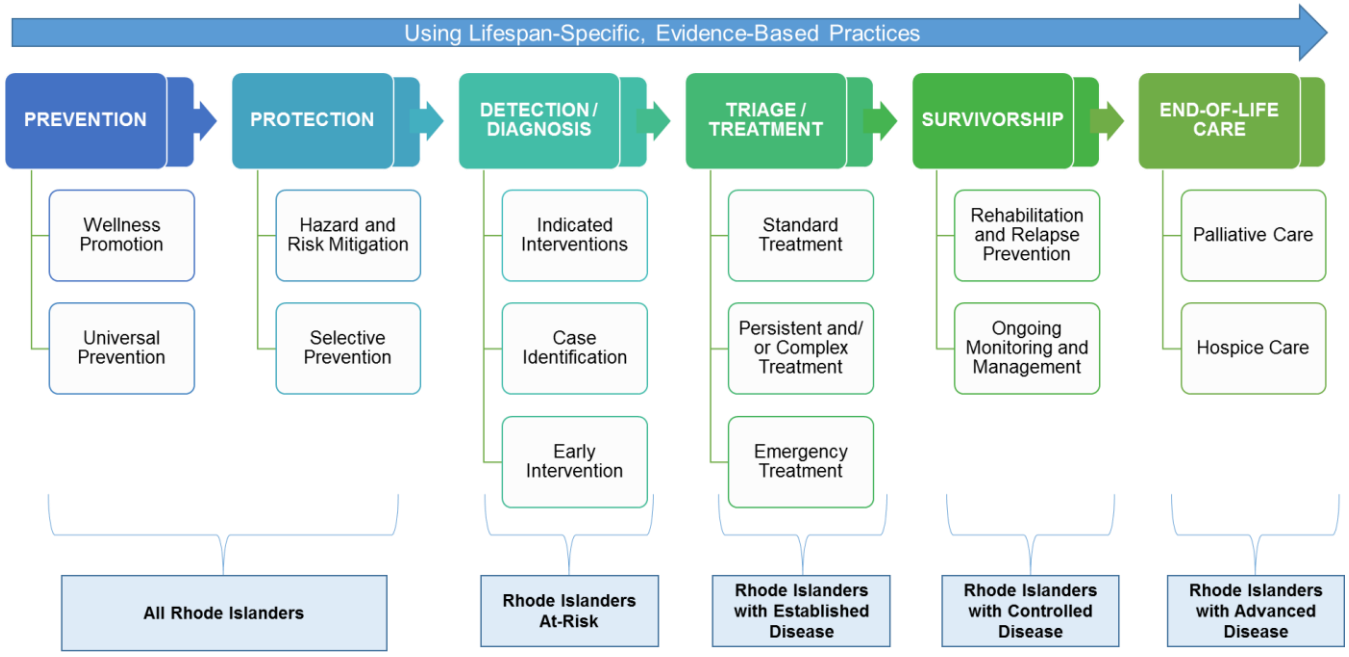
- *Helping individuals connect to disease prevention resources;*
- *Increasing early intervention and referral to reduce late stage presentation of disease; and*
- *Improving outcomes through patient navigation and coordination of physical and behavioral healthcare.*

Critical to these aims is the integration of physical and behavioral health across the care continuum and throughout the lifespan. Progress toward these objectives of SIM can be

catalyzed by creating a common framework for this type of integration, coupled with the use of evidence-based practices along an expanded continuum of care (i.e., one that view patients as people before they enter the health system). The next figure is a depiction of a six-tiered care continuum for integrated physical and behavioral health, developed by Rhode Island for the purposes of SIM. Included within this figure are supportive wellness and care (i.e., for both behavioral and physical needs) elements. From our perspective, it is important to think about preventing the need for care, protecting those from being at-risk for needing care, ultimately detecting the need for care, treating the care need, and recovering from the needed care.

Figure 10

Integrated Physical and Behavioral Health Care Continuum



Rhode Island State Innovation Model, (2016).

The Integrated Physical and Behavioral Health Continuum (See Figure 5) borrows from the cancer care continuum[6] to create a comprehensive integrated population health approach. This model also helps identify the appropriate target population across the continuum for our measurement and intervention efforts.

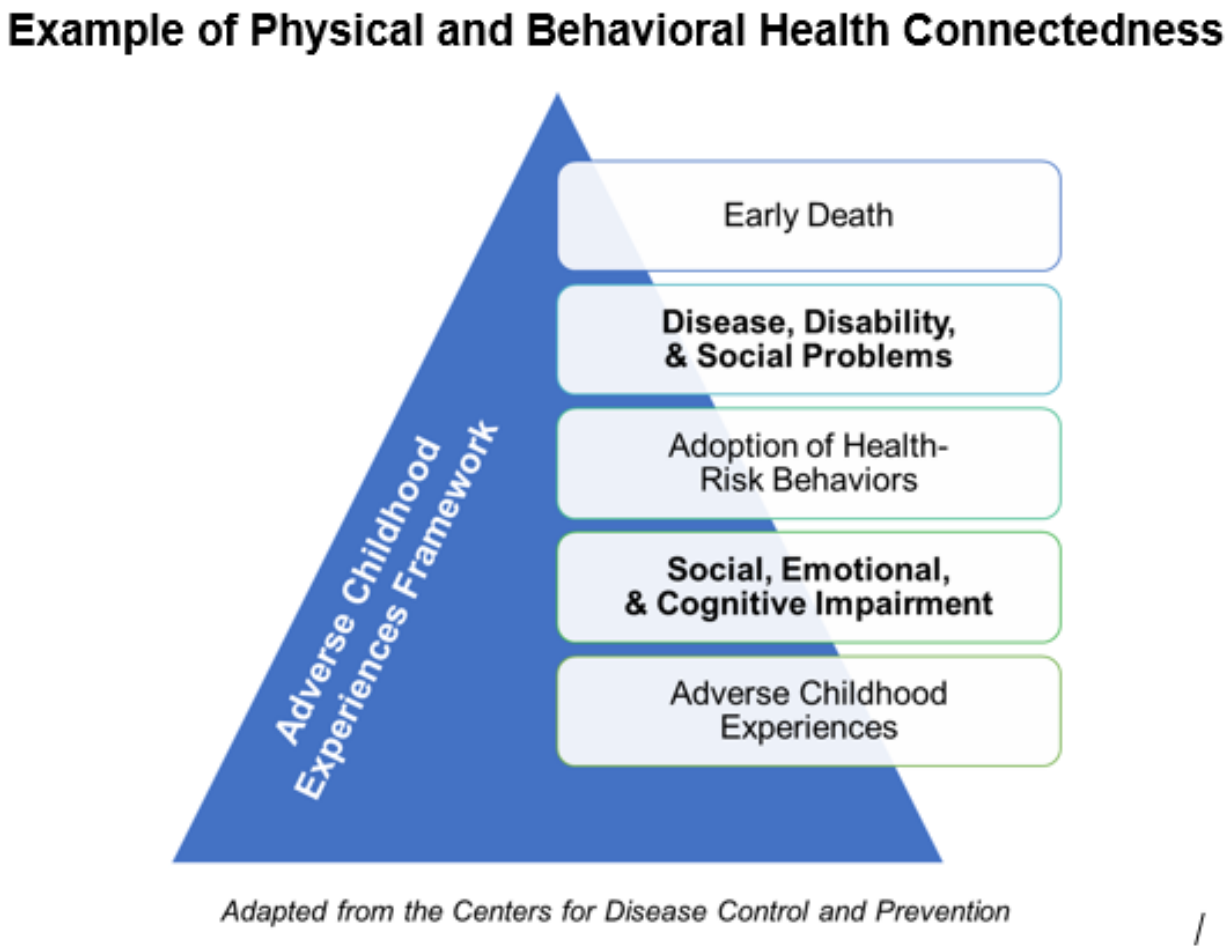
In a measurement example, when a health-related treatment variable is assessed at the clinical practice level then the "population" might be the patients within that clinical practice. However, when the health-related prevention variable is measured by a statewide population survey (e.g. the Behavioral Risk Factor Surveillance System) then the population is the entire state. We will continue to use this model during the population health measures generation process and the intervention evaluation process to ensure we are measuring and intervening on population health across the care continuum from prevention to end of life care.

To illustrate the interconnectedness of the physical and behavioral health spheres, we looked at other frameworks supporting our approach. The Centers for Disease Control and Prevention

[6] Hewitt M. Simone J. eds. . The Institute of Medicine Report, Ensuring Quality Cancer Care, 246 National Academy Press Washington, DC 1999.

(CDC) developed a framework for Adverse Childhood Experiences. In this framework, noted in the figure below, one can see the progression of potential care needs throughout the care continuum as impairments can lead to behaviors which can lead to disease (i.e., both physical and behavioral). A serious emotional disturbance within childhood can carry across the life course and lead to early death.

Figure 11



Clinical Approaches to Integration

Central to the IPHP and the SIM project in general is a desire to provide Rhode Islanders with the right care at the right place and the right time. The four quadrant integration model describes the optimal type of treatment or care for Rhode Islanders depending on the complexity and severity of their condition.

Figure 12

The Four Quadrant Clinical Integration Model[7]

Behavioral Health Risk/ Complexity		
Hi	**Quadrant II** **BH – Hi PH - Lo** • Behavioral health clinician/case manager w/ responsibility for coordination w/ PCP • PCP (with standard screening tools and guidelines) • Out-stationed medical nurse practitioner/physician at behavioral health site • Specialty behavioral health • Residential behavioral health • Crisis/ED • Behavioral health inpatient • Other community supports	**Quadrant IV** **BH – Hi PH - Hi** • PCP (with standard screening tools and guidelines) • Out-stationed medical nurse practitioner/physician at behavioral health site • Nurse care manager at behavioral health site • Behavioral health clinician/case manager • External care manager • Specialty medical/surgical • Specialty behavioral health • Residential behavioral health • Crisis/ ED • Behavioral health and medical/surgical inpatient • Other community supports
Lo	**Quadrant I** **BH – Lo PH - Lo** • PCP (with standard screening tools and behavioral health practice guidelines) • PCP-based behavioral health consultant/care manager • Psychiatric consultation	**Quadrant III** **BH – Lo PH - Hi** • PCP (with standard screening tools and behavioral health practice guidelines) • PCP-based behavioral health consultant/care manager (or in specific specialties) • Specialty medical/surgical • Psychiatric consultation • ED • Medical/surgical inpatient • Nursing home/home based care • Other community supports
	Low	**Physical Health Risk/Complexity** **High**

Adapted from the National Council for Community Behavioral Healthcare (2009).

[7] Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home, the National Council for Community Behavioral Healthcare, 2009.

Assessment of Population Health Burden

This section of the IPHP describes the current overall health of Rhode Islanders and the overarching physical and behavioral health burdens through the use of a variety of data sources. Also included, where applicable, are specific measures exploring the prevalence, social trends, and communities disproportionately affected by our health focus areas. These data are also supported by recent findings from related health assessments included at the end of this section.

A Snapshot of Rhode Island's Health

In Rhode Island, the focus continues on ensuring better health, at a lower cost, for all Rhode Islanders. More specifically, SIM's multi-sectoral collaborative approach renewed focus on reducing disease risk factors, disease morbidity and mortality, and incidence of poor social context (i.e., where health happens) has resulted from the Rhode Island SIM Test Grant's multi-sectoral collaboration. This inclusive approach is committed to addressing multiple pathways that lead to poor health and overall life satisfaction.

Rhode Island performs well across many health outcomes, Rhode Island is doing quite well. For example, in 2010 RI ranked 13th in the US for life expectancy at birth at 79.9 years. Data from 2014 suggest that 85% of Rhode Islanders generally rate their health as good, very good, or excellent. And due to effective tobacco control efforts, Rhode Island has the third lowest youth smoking rate in the US (4% in 2013). We also ranked number one for immunization rates among children and teens in 2014.

Life Expectancy and Potential Years Lost

However, for other health and well-being indicators, there are still areas of improvement. In Rhode Island, cancer tops the list of leading causes of death that reduce life expectancy. On average, cancer reduces years of potential life lost by 22.7, more than two years over the national average. Our average number of years of potential life lost due to perinatal conditions is also above the national average. On average, these conditions reduce the lives of Rhode Islanders by 7.7 years, more than two years above the national average. In all of the other major leading causes of death, Rhode Island is close or below the national average of years of potential life lost.

Figure 13

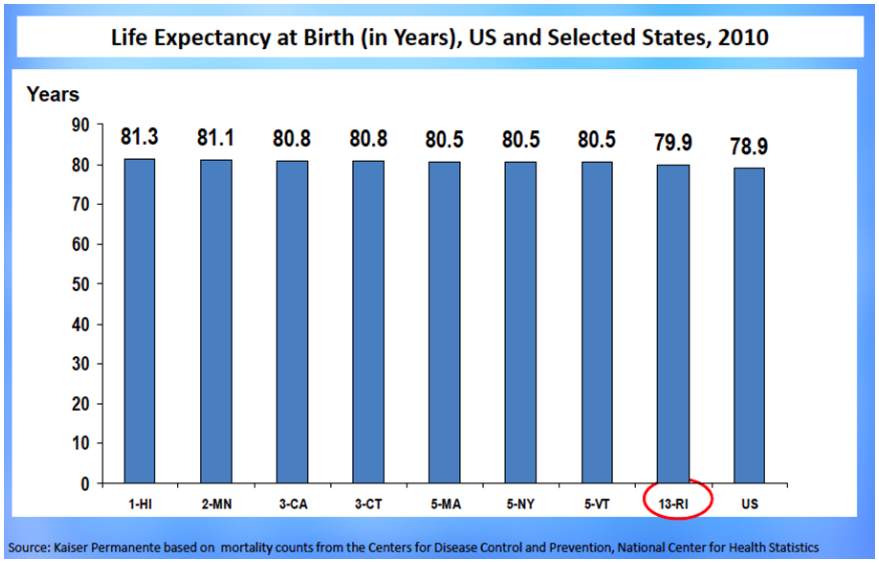
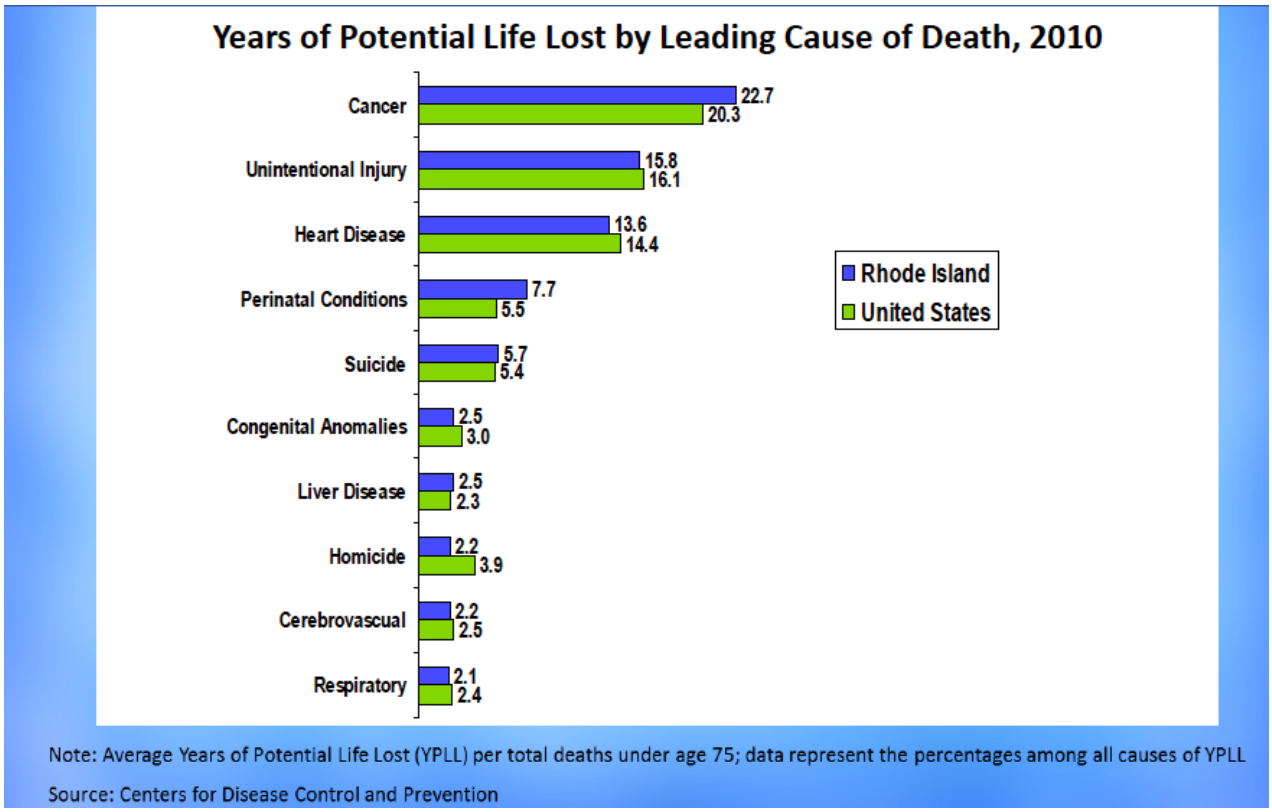


Figure 14



Health-Related Quality of Life

While an assessment of chronic condition, health behaviors, and life expectancy provide very useful data for population health planning efforts, such measures are limited in their ability to describe the quality of the physical, mental, and social domains of life.[8] Health-related quality of life (HRQoL) is a measure that considers these domains in the context of health and disease. Well-being, which refers to the "state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life"[9] is a related concept. To highlight the importance of HRQoL and well-being, Healthy People 2020 includes a goal to "improve health-related quality of life and well-being for all individuals."[10] In Rhode Island, data from the 2014 BRFSS indicate that 12% of Rhode Islanders report 14 or more days out of the past 30 during which physical health was not good, and 13.3% during which mental health was not good. In addition, those experiencing cost barriers to care are more likely to report 14 or more days where physical and mental health was not good, compared to those not reporting cost barriers to care (see Figures below).

[8] https://www.healthypeople.gov/sites/default/files/HRQoLWBFullReport.pdf
[9] https://www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-life-well-being
[10] https://www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-life-well-being

Figure 15

Prevalence of Those Reporting 14 or More Days Out of the Past 30 during which Physical Health Was Not Good

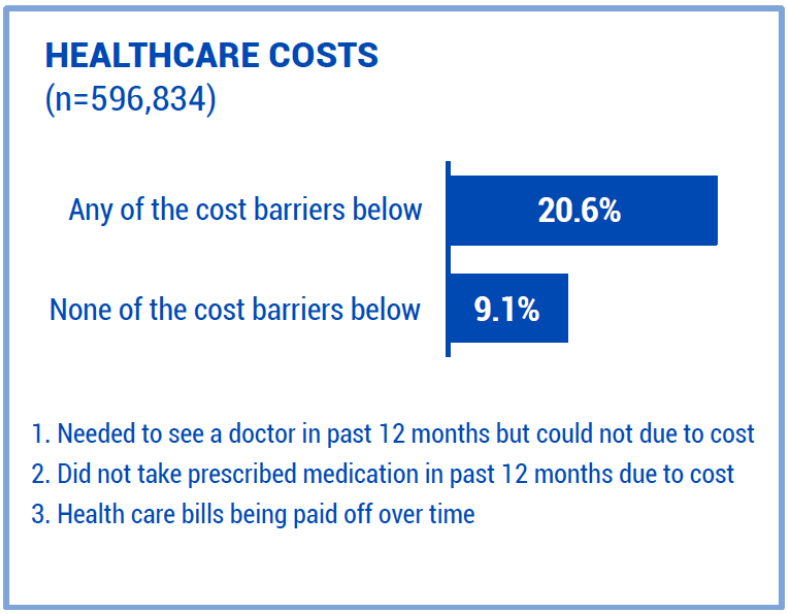
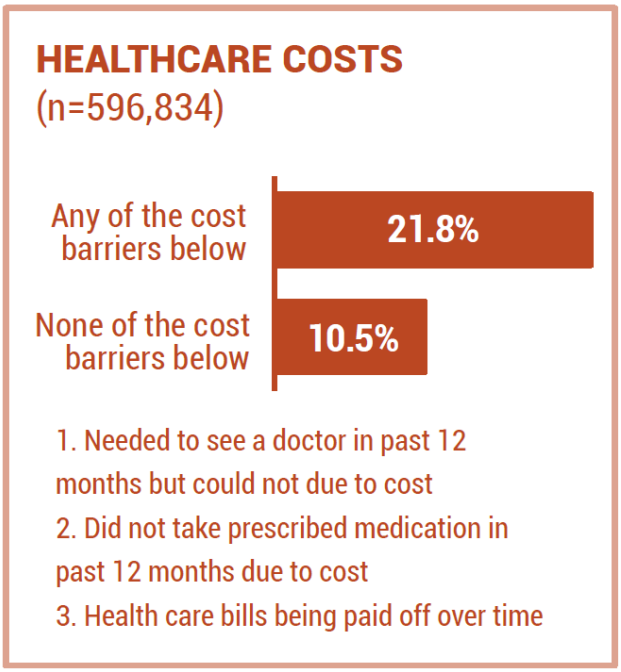


Figure 16

Prevalence of Those Reporting 14 or More Days Out of the Past 30 during which Mental Health Was Not Good

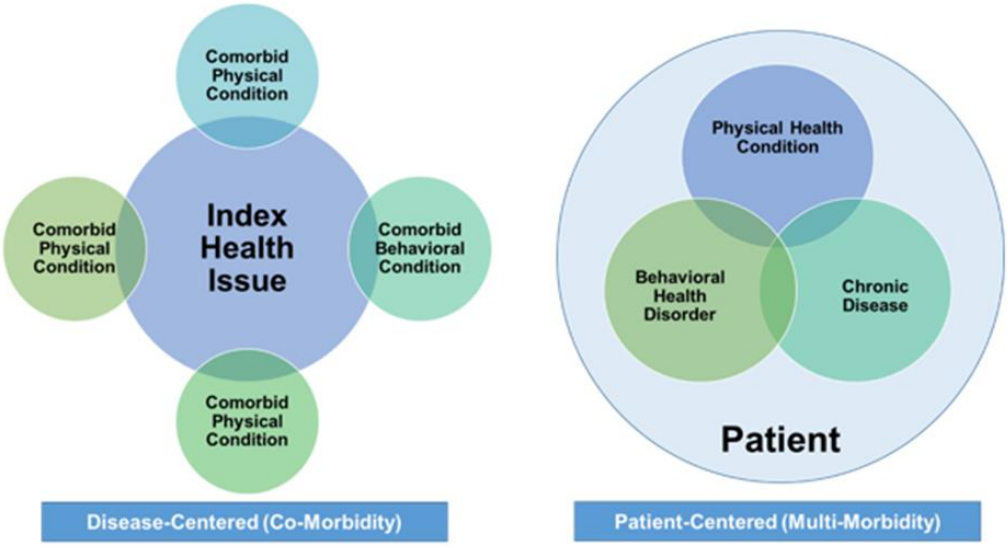


Co-Morbidity and Multi-Morbidity

As we explore each individual health focus area, we will continue to examine data related to the presence of multiple chronic conditions, known as "multi-morbidity." Multi-morbidity is associated with increased use of health services and is negatively associated with adult socioeconomic status and socioeconomic status in childhood.[11] [12] [13] Our team also acknowledges that none of these specific diseases, conditions or behaviors exist in isolation. In many cases, it is the combined effect of these health focus areas that have an especially detrimental effect on the wellbeing of Rhode Islanders. The next figure depicts Rhode Island's integrated approach to co- and multi-morbidity.

Figure 17

Co-Morbidity and Multi-Morbidity Models



Adapted from Boyd, C. and Fortin, M. (2010)

Chronic conditions are generally clustered and individuals with one chronic condition are likely to have other conditions as well. Approximately 1 in 4 Americans are managing more than one ongoing health condition and chronic conditions become more common as we age. According to the Centers for Disease Control and Prevention (CDC), 21% of Americans between the ages of 45-64 have two or more chronic conditions. This percentage increases to 45% for those aged 65 and older.[14] The impending shift in the US population demographic as the baby-boomers reach age 65 will yield an elderly population characterized by declining death rates, increasing life expectancy, and increasing health care cost, accompanied by a continued rise in multi-morbidity. This continued rise poses significant challenges to the single disease focus of the public health and healthcare delivery system (and other systems that influence our health).

[11] Payne, R. A., Abel, G. A., Guthrie, B., & Mercer, S. W. (2013). The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: A retrospective cohort study. *Canadian Medical Association Journal, 285(5).* doi: 10.1503/cmaj.121349

[12] Luo, Y., & Waite, L. J. (2005). The Impact of Childhood and Adult SES on Physical, Mental, and Cognitive Well-Being in Later Life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 60(2). doi: 10.1093/geronb/60.2s93

[13] Tucker-Seely, R. D., Li, Y., Sorensen, G., & Subramanian, S. (2011). Lifecourse socioeconomic circumstances and multimorbidity among older adults. *BMC Public Health,* 11(1). doi: 10.1186/1471-2458-11-313

[14] http://www.cdc.gov/nchs/data/databriefs/db100.htm

Furthermore, of the 58,000 adults and 12,000 children who were treated at a Community Mental Health Center (CMHC) between 7/1/2012 and 6/30/2015:

- *54% had a medical claim associated with treatment for a co-occurring heart condition*
- *5.9% had a medical claim associated with treatment for a respiratory disorder.*

In addition, in a number of studies, the use of antipsychotic medications is linked with weight gain, diabetes, dyslipidemia, insulin resistance, and the metabolic syndrome.[15] The clustering of physical chronic conditions with mental illness presents substantial care coordination, medication management, and patient adjustment issues that all influence the cost of care.

Figure 18

Rhode Islanders Age 18-64 Who Experienced 14 or More Days Out of the Past 30 during which Health Was Not Good

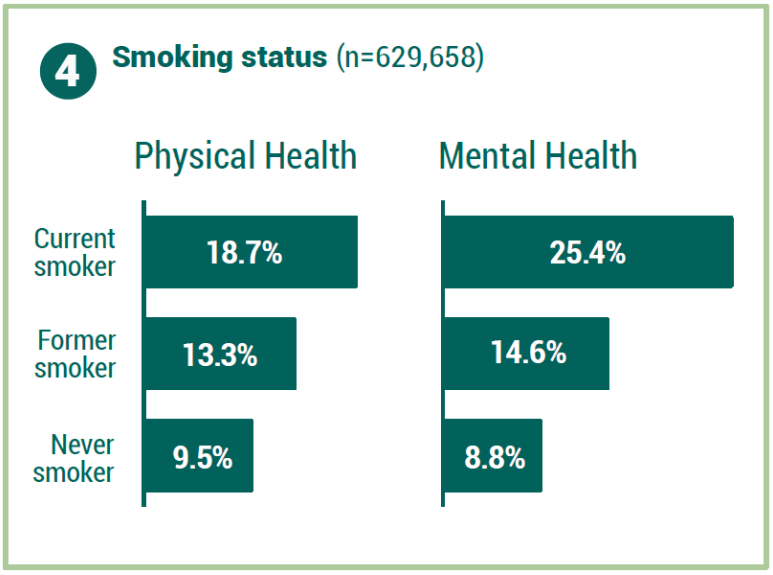


Figure 12 (see above) depicts data from the 2014 BRFSS which indicates that smoking status affects the prevalence of 14 or more days in which health was not good among groups in Rhode Island. Both physical and mental health showed similar differences, further making the case for integrated care for multiple health issues.

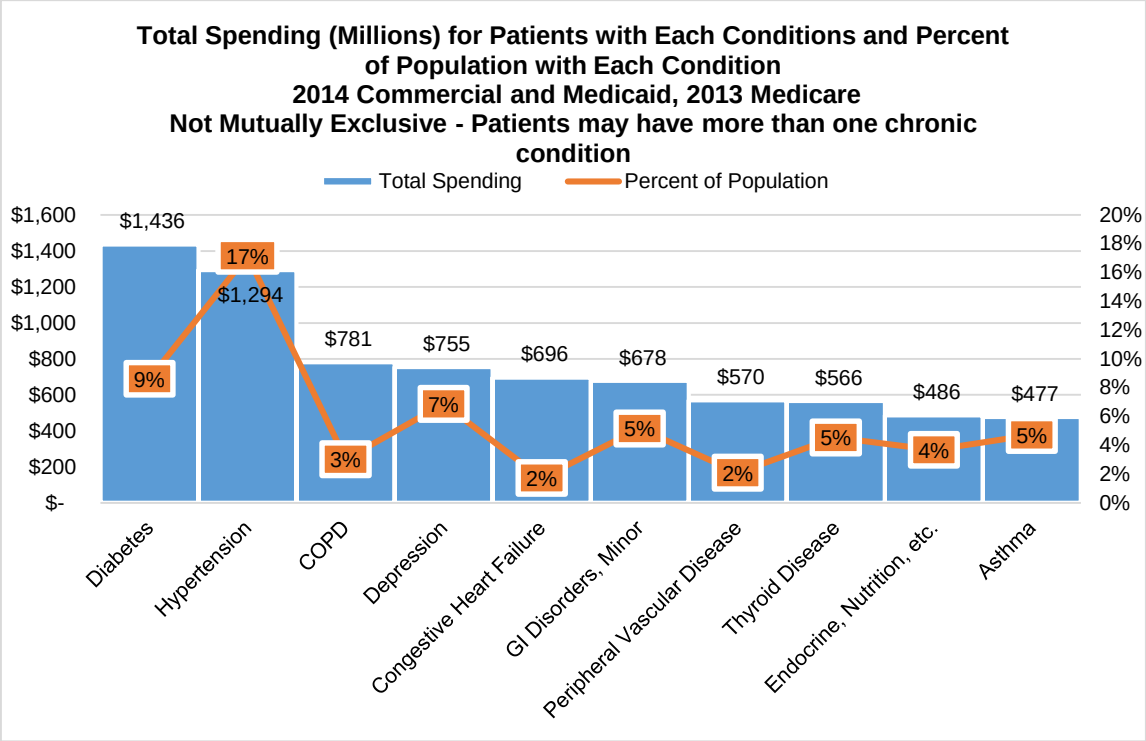
Costs of Healthcare in Rhode Island

The costs of navigating healthcare and managing one's health can be costly to the family and to the healthcare delivery system. In the community sample used in the Rhode Island Department of Health 2015 Statewide Health Inventory, 31% reported delaying or putting off medical care because of cost, and almost half (47%) of those who delayed care reported that they became sicker before they received care. Reported cost barriers to care included high deductibles and co-pays. In Rhode Island, people with diabetes account for $1.4 billion in health care spending annually, while people with hypertension account for nearly $1.3 billion.

[15] Tucker-Seely, R. D., Li, Y., Sorensen, G., & Subramanian, S. (2011).

Figure 19

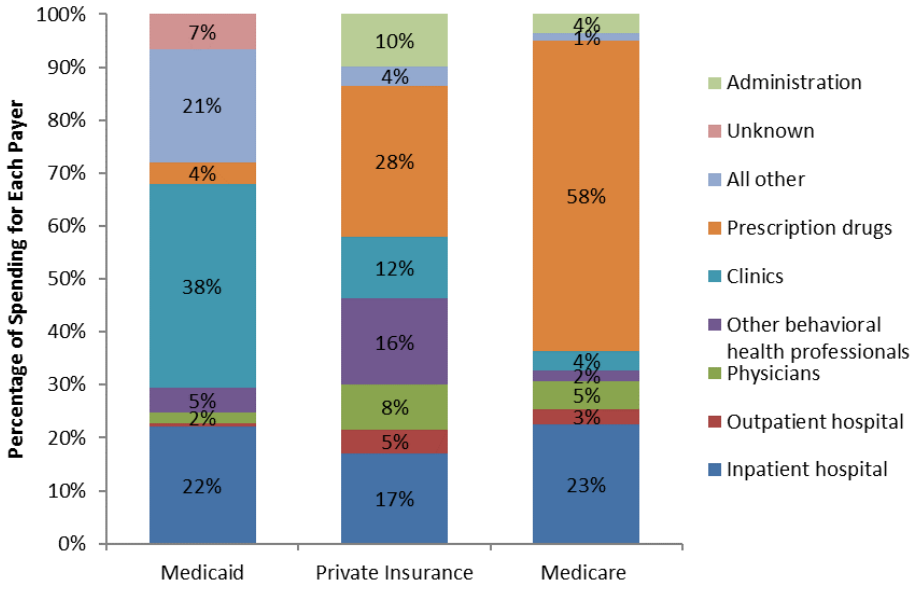
Ten Most Expensive Chronic Conditions in Rhode Island



In 2013, Rhode Island spent $853 million on direct costs for behavioral health treatment; this represented 1.6% of the gross domestic product, greater than the national average of 1.2%. The average medical cost per person with a behavioral health disorder in Rhode Island was higher than any other state in New England.[16]

Figure 20

Distribution of Behavioral Health Spending in Rhode Island by Medicaid, Private Insurance, and Medicare, 2013*



[16] Truven Health Analytics. (2015b). *Rhode Island Behavioral Health Project: Cost Report*.

Spending per enrollee or per population on behavioral health treatment among Rhode Island residents with Medicaid, private insurance, and Medicare coverage is generally higher than spending in any other New England state. The high utilization of inpatient hospitalizations and greater spending on prescription drugs is consistent across payer types and likely contributes to the higher Rhode Island spending levels.

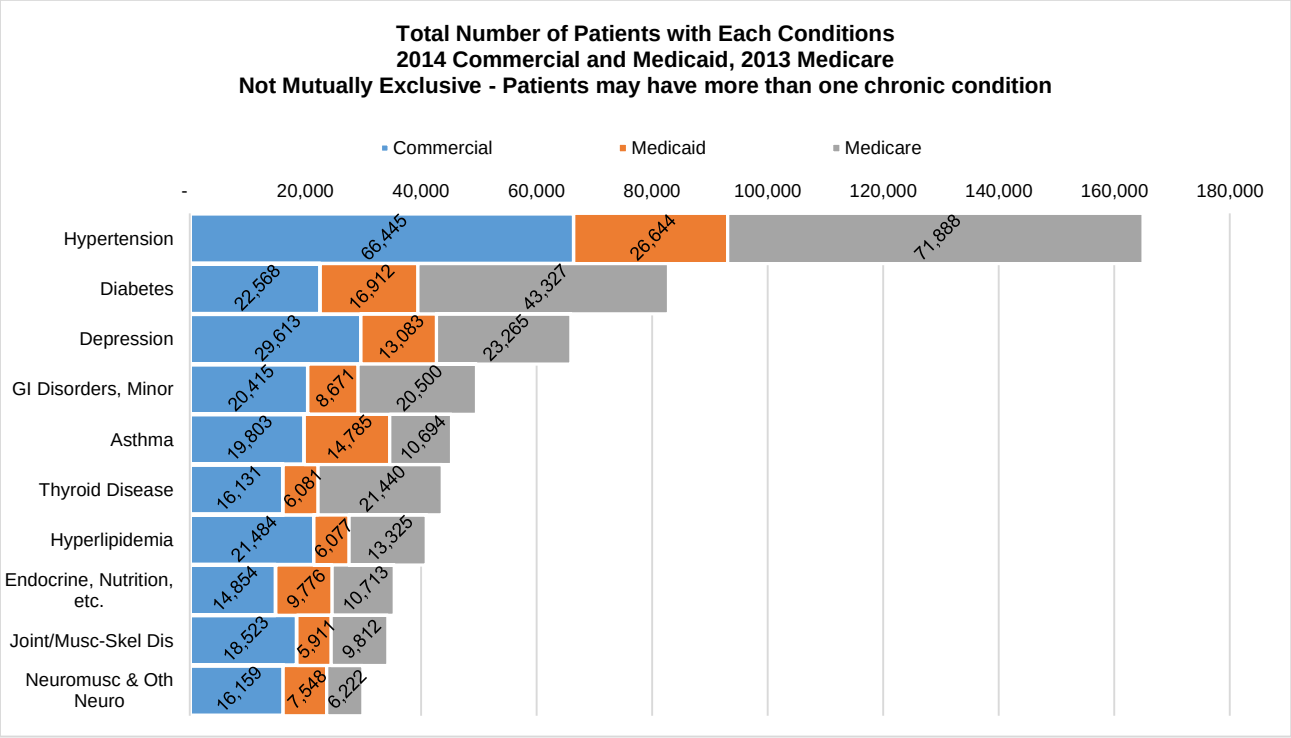
In addition to the direct costs, according to an analysis by Truven Analytics, an estimated $789 million, 9.5% of the state's 2015 budget, was attributed to indirect costs associated with behavioral health disorders, costs attributed to the Department of Children Youth and Families, the Department of Human Services, disability benefits, the Department of Corrections, and public safety.[17]

Summary of Physical and Behavioral Health Burdens

Physical Health Morbidity

Chronic conditions affect a substantial number of Rhode Islanders; and Rhode Island ranks 17th in the nation for adult smoking rates. Hypertension, diabetes, and depression are the most common chronic conditions in Rhode Island, affecting roughly 165,000, 83,000, and 66,000 insured Rhode Islanders respectively. Our prevalence rates for other chronic conditions for adult Rhode Islanders include: obesity (27%), cardiovascular disease (6.4%), and depression (20.6%). The rates are all below the national averages for these conditions.

Figure 21
Top Ten Most Prevalent Chronic Conditions among insured Rhode Islanders (2014)



[17] Truven Health Analytics. (2015b).

Chronic conditions are the leading cause of death and disability; and while Rhode Island overall is doing well compared to national rates for the chronic conditions listed above, some groups are faring worse than others. We know that rates of hypertension and diabetes increase with age and approximately 65% of older Rhode Island adults have hypertension.[18] Additionally, Rhode Islanders (18-64) who are on Medicaid or Medicare have higher rates of chronic diseases, such as diabetes. In 2010, the rate of diabetes was 15% for Rhode Islanders on Medicaid or Medicare, compared to only 5% in the privately insured population. Additionally, obesity rates were 36% for Medicaid and 25% for the privately insured.[19] The prevalence in Rhode Island of diagnosed diabetes is highest among Black/African American adults (15.7%) and Hispanic adults (13%), compared to Non-Hispanic White adults (6.7%).[20]Low-income adults aged 20 to 64 years are more likely to report two or more modifiable risk factors (e.g. smoking, high blood pressure, overweight/obesity, or physical inactivity) than adults in this age group with household incomes of $50,000 a year and higher (55.0% versus 35.9%).[21]

Figure 22

Rhode Island and US Chronic Condition / Health Behavior Prevalence Rates

Condition/Health Behavior	RI Prevalence Rate	US Prevalence Rate
Obesity[22]	27% (2014)	28.9% (2014)
Cardiovascular disease[23]	6.4% (2014)	6.7% (2014)
Diabetes	8.3% (2014)	9.3% (2014)
Adult smoking rate	17.4% (2013)	19.0 (2013)

National research indicates that behavioral health issues have a significant impact on an individual's lifespan and overall health. According to a study reported by the National Center for Biotechnology Information, adults with serious mental health disorders had a significantly higher rate of mortality than similar populations without mental health disorders. A total of 67.3 percent of deaths among those study participants were from medical causes[24]. Studies also show that people with severe mental illness have a reduced lifespan of at least 10 years.

Behavioral Health Morbidity

The presence of behavioral health disorders among children in Rhode Island is a serious concern. More than one in five children had one or more "emotional/behavioral conditions."[25] Children are exposed to a number of risk factors that can lead to behavioral health disorders, including high rates of poverty, living with mothers and/or fathers with behavioral health disorders, living in less positive home environments, and exposure to trauma. Between 2011 and 2012, 9.3% of children in Rhode Island aged 6 to 11 years old were living with mothers in poor mental health, higher than any other New England state and above the national average of 7.9%.[26]

The rates of Rhode Island children suffering from recurrent child abuse and neglect and abuse/neglect while in foster care placement exceed national standards[27]. In addition, protective

[18] http://www.health.ri.gov/publications/databriefs/2013AdultHealthRisks.pdf
[19] HEALTH INDICATOR DATA BOOK. A Comparison of Access and Quality Measures for Rhode Islanders <65 years old by Health Insurance Coverage – Trends 2000-2012
[20] http://www.health.ri.gov/publications/stateplans/2010-2015Diabetes.pdf
[21] Data from the 2011 Rhode Island Behavioral Risk Factor Surveillance System
[22] Centers for Disease Control and Prevention. https://nccd.cdc.gov/NPAO_DTM/IndicatorSummary.aspx?category=28&indicator=29
[23] KCMU analysis of the Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2014 Survey Results. http://kff.org/other/state-indicator/percent-of-adults-with-cardiovascular-disease/

[25] Kids Count Data Center. (2013) *Children Who Have One or More Emotional, Behavioral, or Developmental Conditions.*
[26] Truven Health Analytics. (2015a). *Rhode Island Behavioral Health Project: Demand Report*.
[27] Rhode Island Department of Children, Youth, and Families. (2016). *Child Welfare.* Retrieved from: www.dcyf.ri.gov/child_welfare/index.php

factors, such as enrollment in nursery school or preschool, are less prevalent among young children in Rhode Island than in the rest of the country. Children and adolescents in Rhode Island have high rates of depression, and the rates of ADHD diagnosis and use of marijuana and other illicit drugs exceeds the national average.[28] The need for substance use disorder treatment among children and adolescents in facility placement almost tripled between 2009 and 2011[29].

Behavioral health disorders are a concern for adult Rhode Islanders as well. The rate of adults diagnosed with depression is 20.6% and 4.9% of Rhode Islanders have experienced a serious mental illness in the past year, exceeding national averages. The rate of binge drinking among Rhode Islanders exceeds the national average. More than one in five adults, aged 18 to 24 years old, reported alcohol and/or drug abuse/dependence; this rate increased for Rhode Islanders during the same time that the national rate decreased. Reported drug use in the past month among 25 – 64 year old Rhode Islanders is almost double the national average.[30]

Assessment of SIM Health Focus Areas

Prevalence and cost to Rhode Island motivated the selection of the following health focus areas: tobacco use, obesity, chronic diseases, depression, serious mental illness, opiate use disorders, and children with social and emotional disturbance.

Addressing the high prevalence and substantial cost of these health areas is a high priority across our state. Our interagency leadership chose to expand the scope of diabetes to include two other major chronic illnesses because of input from the state department of health. We also added specific behavioral health morbidities because of the high priority the Steering Committee placed on addressing behavioral health needs. With more time, the team working on the population health plan will explore other interests of the Steering Committee including topics specifically related to children's health.

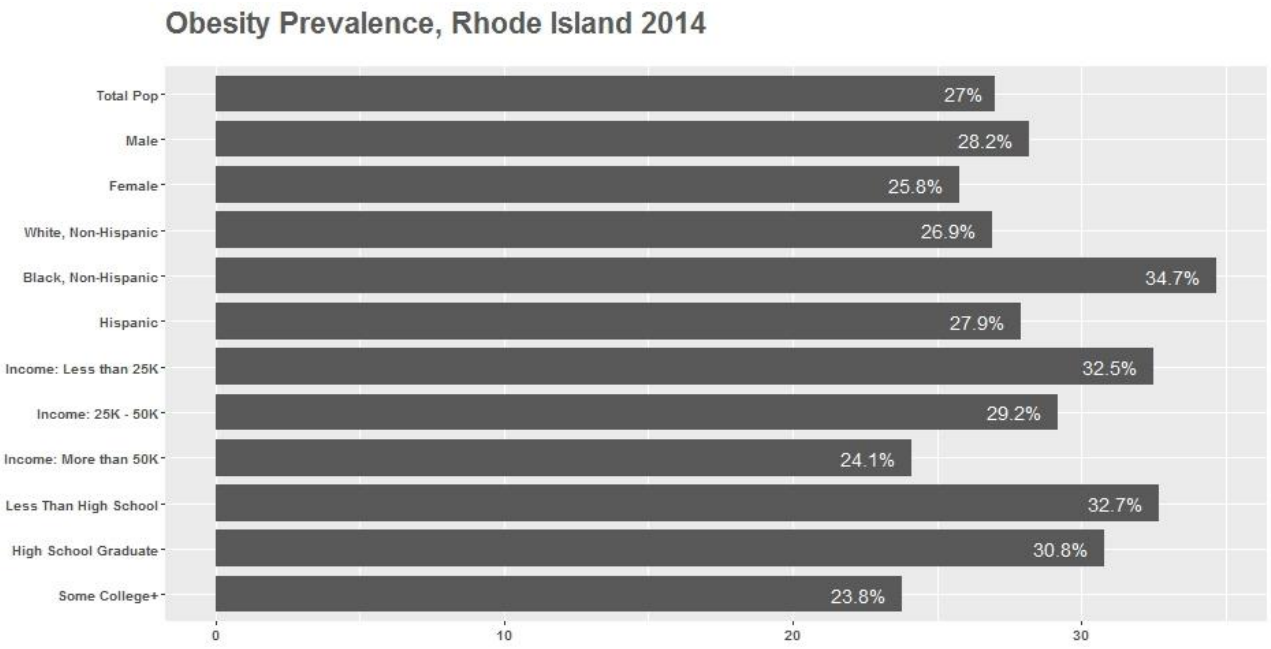
Obesity: Health Focus Area 1

Definition
Obesity is defined by the ratio of an individual's weight to their height, called the Body Mass Index (BMI). An individual is considered obese of they have a BMI of 30-99.8. To determine the prevalence of obese Rhode Islanders, this report combines the results of two questions from the Rhode Island Behavioral Risk Factor Surveillance System (BRFSS): "About how much do you weigh without shoes?" and "About how tall are you without shoes?" The answers to these questions form the variables needed to calculate BMI. All Rhode Islanders with a resulting BMI score of 30 or higher are classified as obese.

Prevalence
Overweight and obesity have been increasing at alarming rates in the United States. In 2015, every state had an adult obesity prevalence rate above 20%.[31] Research suggests that overweight and obesity increase the risk for chronic conditions such as diabetes, heart disease, stroke, and specific cancers across the life course.

[28] Truven Health Analytics. (2015a).
[29] Truven Health Analytics (2015a).
[30] Truven Health Analytics. (2015a).
[31] http://stateofobesity.org/adult-obesity/

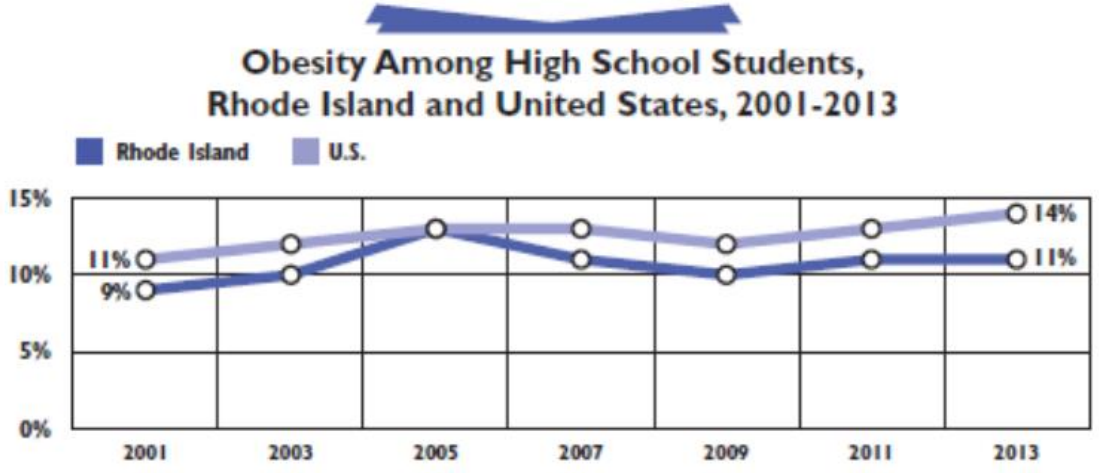
Figure 23



At-Risk Populations and Disparities

The rate of obesity among adolescents in Rhode Island increased slightly since 2009.Among children in Rhode Island, Hispanic children and children from the core cities are more likely to be overweight or obese compared to non-Hispanic white children and children living outside of core cities.[32]

Figure 24



Source: *Youth Risk Behavior Survey*, Rhode Island and National, 2001-2013. BMI calculated using self-reported student response.

[32] Eat Smart Move More, Rhode Island: A Plan for Action 2010-2015: http://www.health.ri.gov/publications/actionplans/2010InitiativeForHealthyWeight.pdf

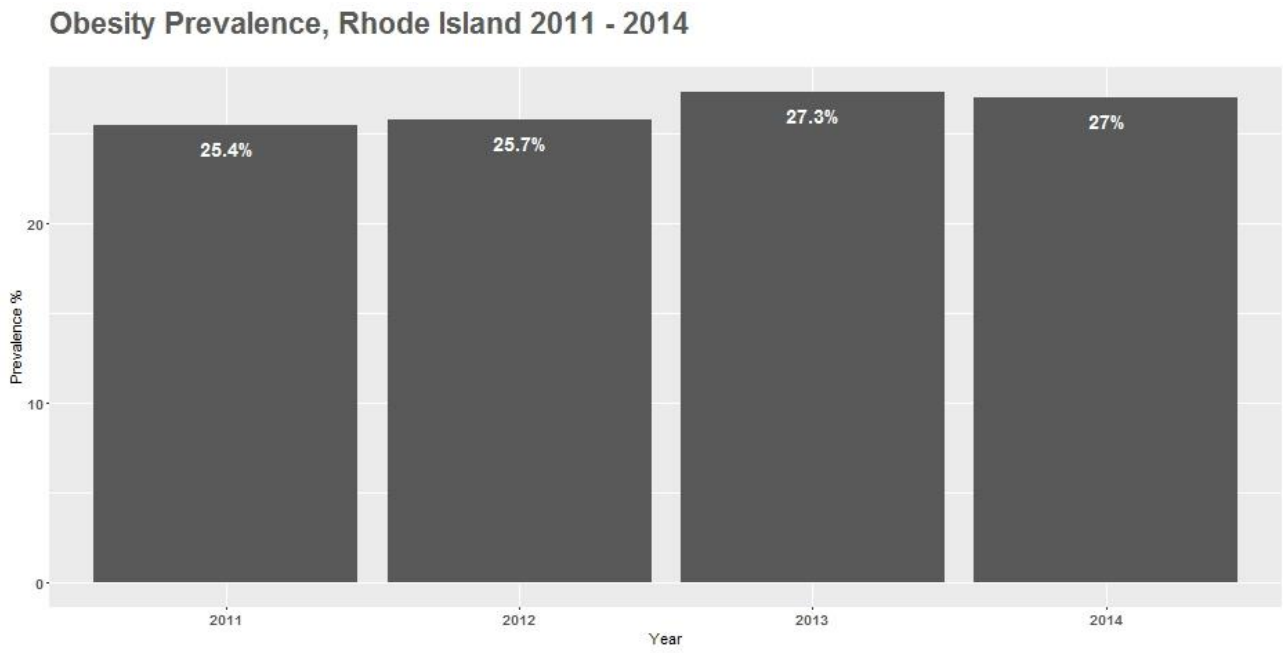
Based on the available data, Black, non-Hispanic Rhode Islanders have the highest rates of obesity at 34.7%. Men are slightly more likely than women to be obese (28.2% of males are obese compared to 25.8% of females).[33] Disparities by income and educational levels exist, but are not as dramatic as the data we see for smoking rates. It is still true that as educational levels and incomes increase, obesity rates decrease. As with smoking rates, national data show that people with behavioral health issues are also more likely to struggle with maintaining a healthy weight.[34] According to Mental Health America:

- *People with Depression are 1.2 to 1.8 times more likely than the general public to be obese.*
- *People with Bipolar Disorder are 1.5 to 2.3 times more likely than the general public to be obese.*
- *People with Schizophrenia are 3.5 times more likely than the general public to be obese.*

Historic Trends

The rate of obese Rhode Islanders has steadily increased over time: between 2011 and2014, obesity rates increased from 25.4% to 27%.[35]

Figure 25



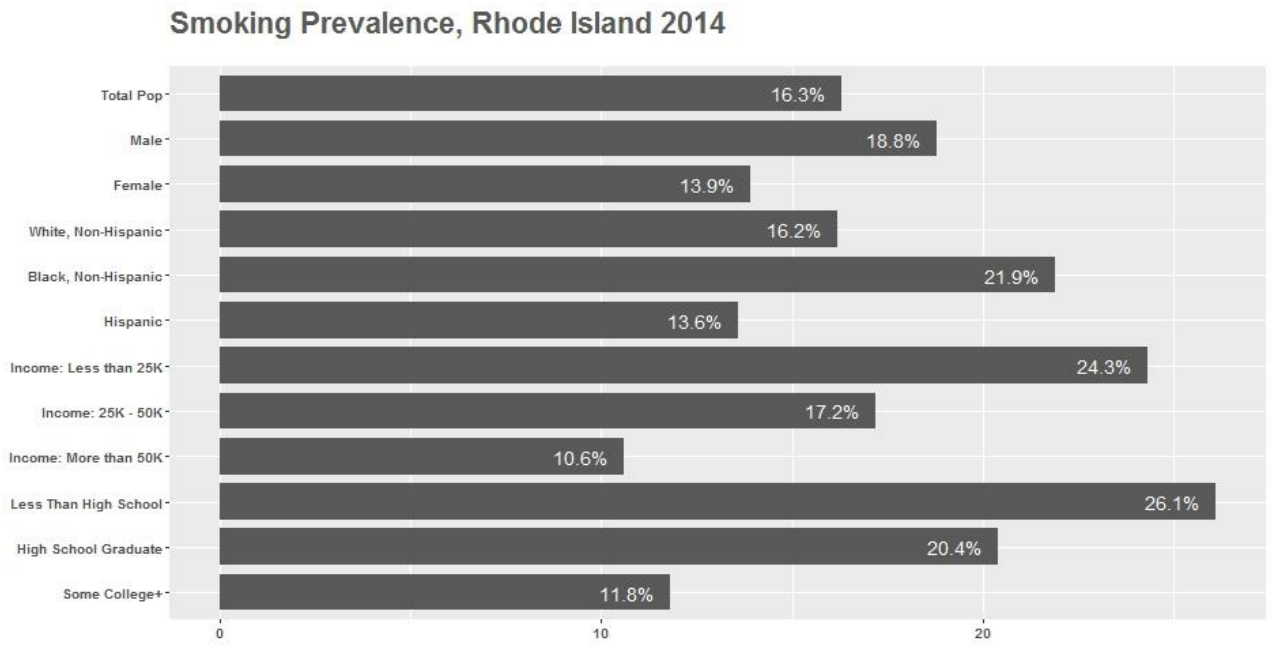
[33] Centers for Disease Control and Prevention. (2015).
[34] *Position Statement 16: Health and Wellness for People with Serious Mental Illnesses*. (2016).
[35] Centers for Disease Control and Prevention. (2015).

Tobacco: Health Focus Area 2

Definition
Although tobacco use encompasses the use of a range of products, from pipes to dipping tobacco, the IPHP focuses primarily on rates of smoking cigarettes. This report measures the prevalence of smokers in Rhode Island using self-reported data from the Rhode Island BRFSS. Rhode Islanders are considered smokers if they answer "every day" or "some days" to the question: "Do you now smoke cigarettes every day, some days, or not at all?"

Prevalence
According to the most recent results from the 2014 Rhode Island BRFSS, 16.3% of Rhode Island adults self-reported that they are smokers.

Figure 26



At-Risk Populations and Disparities
According to the same data source, Black, Non-Hispanic Rhode Islanders are more likely to be smokers than any other racial/ethnic group in the state with a smoking rate of 21.9%. Our analysis of disparities is limited. Small sample sizes among other groups, such as Multi-racial, non-Hispanic Rhode Islanders, prevent us from drawing any conclusions about racial/ethnic communities other than White, Non-Hispanic, Black Non-Hispanic and Hispanic Rhode Islanders. Stratifying the data by income and educational levels shows a more dramatic picture of smoking disparities than stratifying the data by race/ethnicity. Rhode Islanders with an annual household income of less than $25,000 a year self-reported a smoking rate (24.3%) that is more than double the self-reported rate of smokers among Rhode Islanders that have an annual household income of more than $50,000. In general, Rhode Island smoking rates decrease as income increases.

The same is true of educational levels. Rhode Islanders without a high school diploma have the highest rate of smoking, at 26.1%. That rate drops dramatically to 11.8% among Rhode Islanders

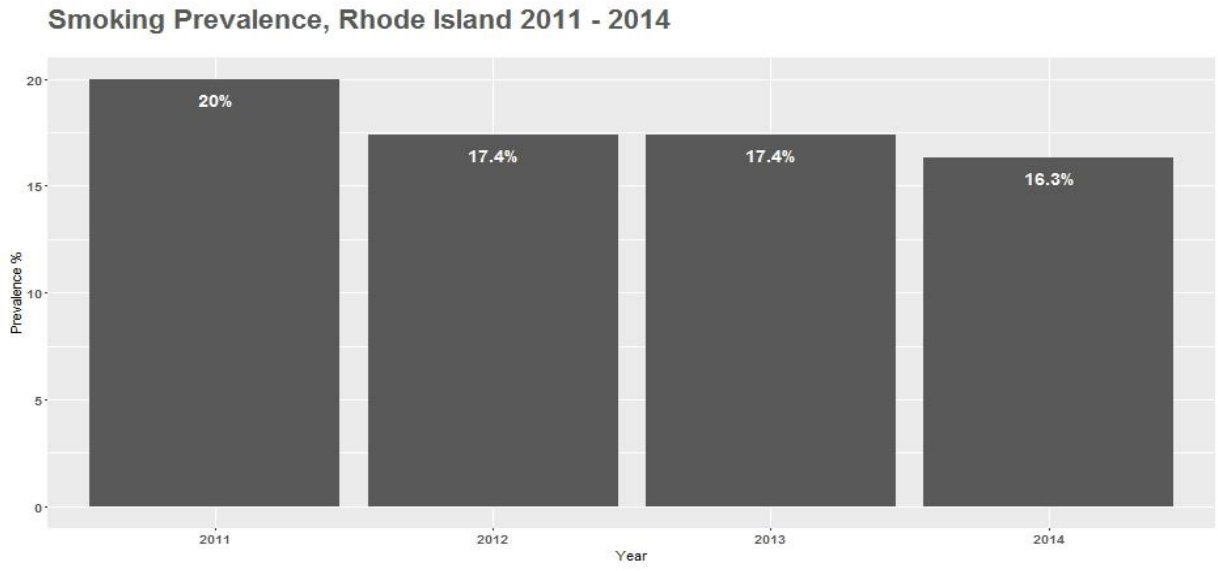
with at least some college education. There are also significant data that indicate people with behavioral health needs have higher rates of smoking than the general public. A Position Statement on Health and Wellness for People with Serious Mental Illness issued by Mental Health America[36] identified that nationally:

- *44% of all cigarettes smoked in the U.S. are consumed by people with a mental illness.*
- *56% to 88% of people with schizophrenia smoke compared to 25% of the general public.*
- *People with schizophrenia who smoke have a higher toxic exposure than other smokers: they smoke more cigarettes and consume more of each cigarette.*

Historic Trends

Although smoking rates vary among Rhode Island's sub-populations, all experienced a decline in smoking over the past 10 years.[37] In the short time span between 2011 and 2014, smoking prevalence dropped from 20% down to 16.3%[38].

Figure 27



[36] *Position Statement 16: Health and Wellness for People with Serious Mental Illnesses*. (2016). *Mental Health America*. Retrieved 18 May 2016, from http://www.mentalhealthamerica.net/positions/wellness

[37] In 2011, the BRFSS began including cell phone numbers for its telephone survey so data before 2011 is not technically comparable to data collected in 2011 and beyond.

[38] Centers for Disease Control and Prevention. (2015). *Behavioral Risk Factor Surveillance System, 2011-2014.* Available from: www.cdc.gov/brfss/annual_data/annual_data.htm

Chronic Diseases: Health Focus Area 3

Definition

Chronic diseases—such as heart disease, stroke and diabetes—are among the most common, costly, and preventable of all health problems.[39] "Four modifiable risk factors—smoking, high blood pressure, overweight/obesity, and the lack of physical activity—are responsible for much of the illness and premature deaths related to these chronic diseases."[40] In this plan, we focus on the diabetes, heart disease, and stroke.

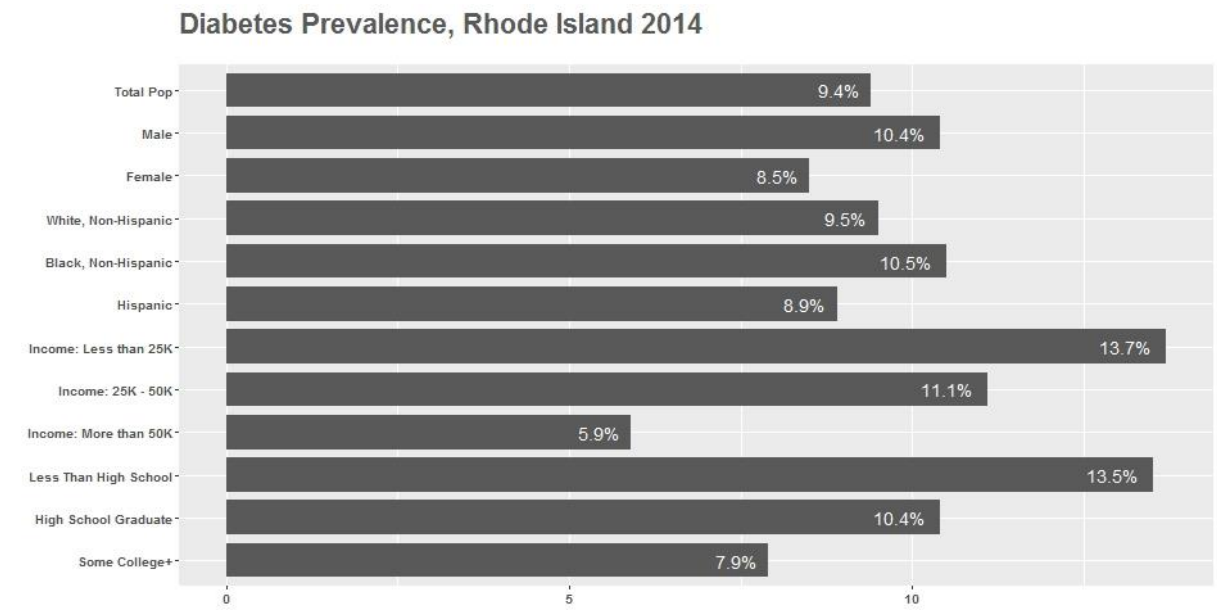
Diabetes

Diabetes is a chronic disease marked by high levels of blood sugar (also called blood glucose). Diabetes occurs when the body has problems either making insulin (Type 1) or using insulin (Type 2). Appropriate interventions can prevent and/or delay the onset of diabetes. Over the past five decades, the prevalence of diagnosed diabetes increased four- to eight-fold, and is projected to continue rising. This report uses data from the Rhode Island BRFSS to calculate the prevalence of diabetes. Rhode Islanders are classified as diabetic if they answer "yes" to the question: "Have you ever been told by a doctor that you have diabetes?"

Prevalence

According to the most recent results from the 2014 BRFSS, 9.4% of Rhode Islanders have been diagnosed with diabetes[41]. Given that approximately one third of people with diabetes remain undiagnosed, the actual prevalence of diabetes in Rhode Island could be much higher.[42]

Figure 28

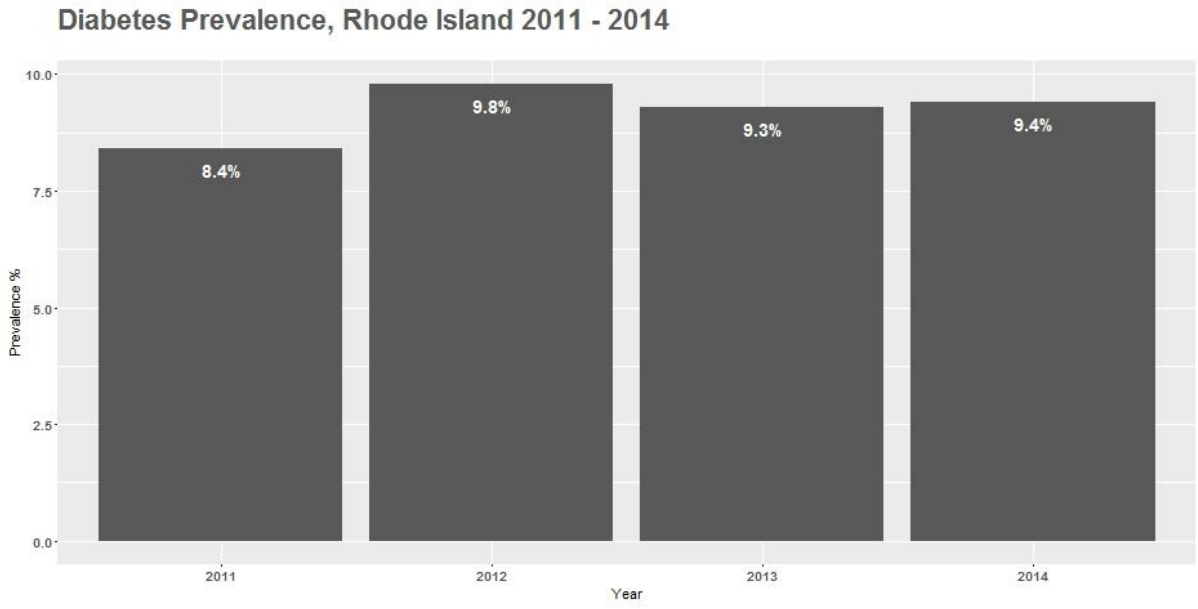


[39] http://www.cdc.gov/chronicdisease/overview/
[40] Danaei G, Ding EL, Mozaffarian D, Taylor B, Rehm J, Murray CJ, Ezzati M. The preventable causes of death in the United States: comparative risk assessment of dietary, lifestyle, and metabolic risk factors. PLoS Med. 2009. 28;6(4).
[41] Centers for Disease Control and Prevention. (2015).
[42] RI Diabetes State Plan 2010-2015: http://www.health.ri.gov/publications/stateplans/2010-2015Diabetes.pdf

At-Risk Populations and Disparities
Black, Non-Hispanic Rhode Islanders show the highest prevalence in this health focus area. However, the difference between racial/ethnic communities is not especially dramatic. In fact, the rate of Black, Non-Hispanic Rhode Islanders with diabetes is statistically the same as the rate of male Rhode Islanders with Diabetes[43]. The more dramatic differences exist when the data are stratified by income and educational levels. As income and educational levels increase, rates of diabetes decrease.

Historic Trends
According to available data, there is a jump in diabetes rates in Rhode Island from 8.4% in 2011 to 9.8% in 2012. In 2013, the rate of diabetes drops slightly and then levels off in 2014[44].

Figure 29



Heart Disease and Stroke (Cardiovascular Diseases)

Cardiovascular diseases include diseases of the heart and hypertension (high blood pressure), as well as cerebrovascular diseases, such as stroke. Modifiable risk factors that increase the risk of developing and dying from cardiovascular diseases include tobacco use, physical inactivity, an unhealthy diet, high blood pressure, high cholesterol, overweight or obesity, and type 2 diabetes.[45]

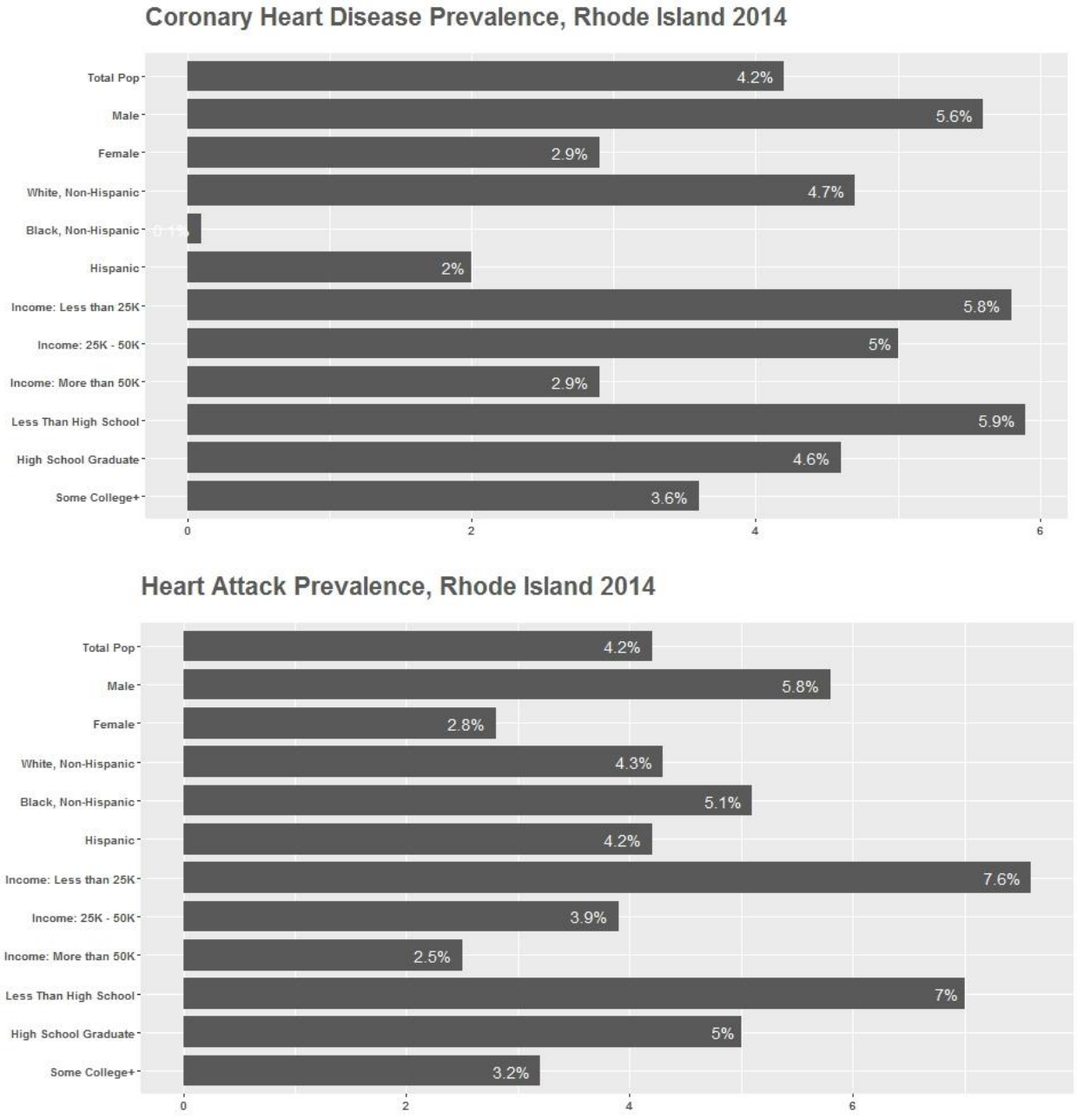
Heart disease and stroke are major causes of disability and cardiovascular diseases remain the leading cause of death in the United States.[46] This plan measures the prevalence of heart disease and stroke in this section using self-reported data from the Rhode Island BRFSS which asks, "Has a nurse, doctor, or other healthcare professional ever told you that you had the following…"

[43] Centers for Disease Control and Prevention. (2015).
[44] Centers for Disease Control and Prevention. (2015).
[45] The Burden of Heart Disease and Stroke: Rhode Island (2009) (http://www.health.ri.gov/publications/burdendocuments/2009HeartDiseaseAndStroke.pdf)
[46] Centers for Disease Control and Prevention, Leading Causes of Death (http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm)

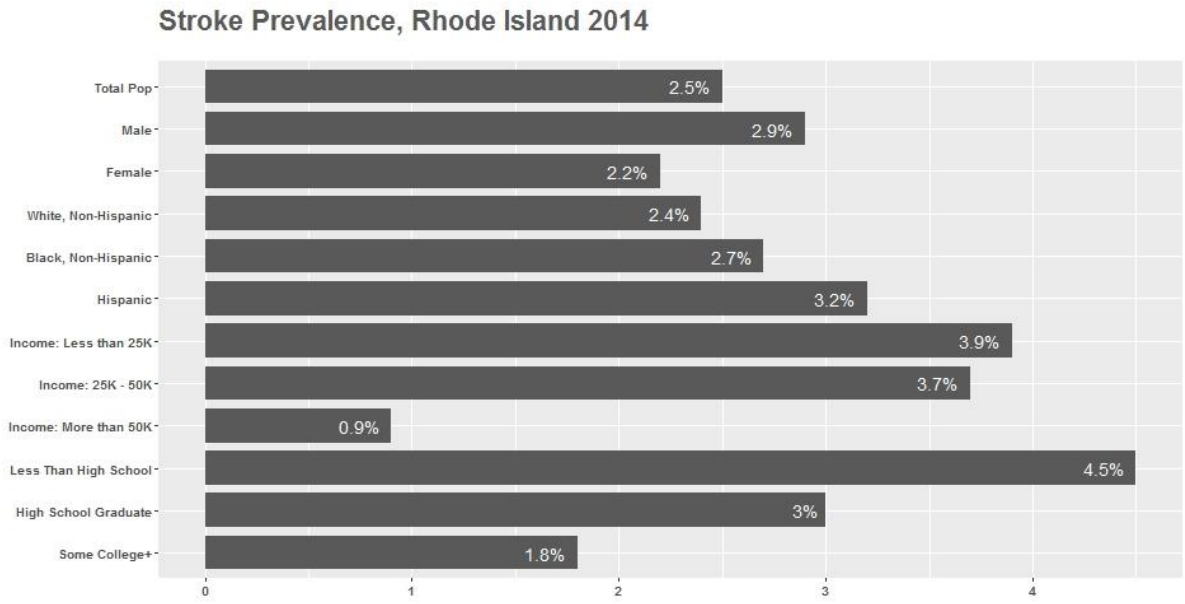
and allows respondents to select among a series of health conditions. Three of those conditions are heart disease/angina, heart attack/myocardial infarction, and stroke.

Heart Disease and Stroke: Prevalence
In 2014, 4.2% of Rhode Islanders reported being told they had Heart Disease/Angina, 4.2% reported being told they had have a heart attack/myocardial infarction and 2.5% reported being told they had a stroke[47].

Figure 30



[47] Centers for Disease Control and Prevention. (2015).



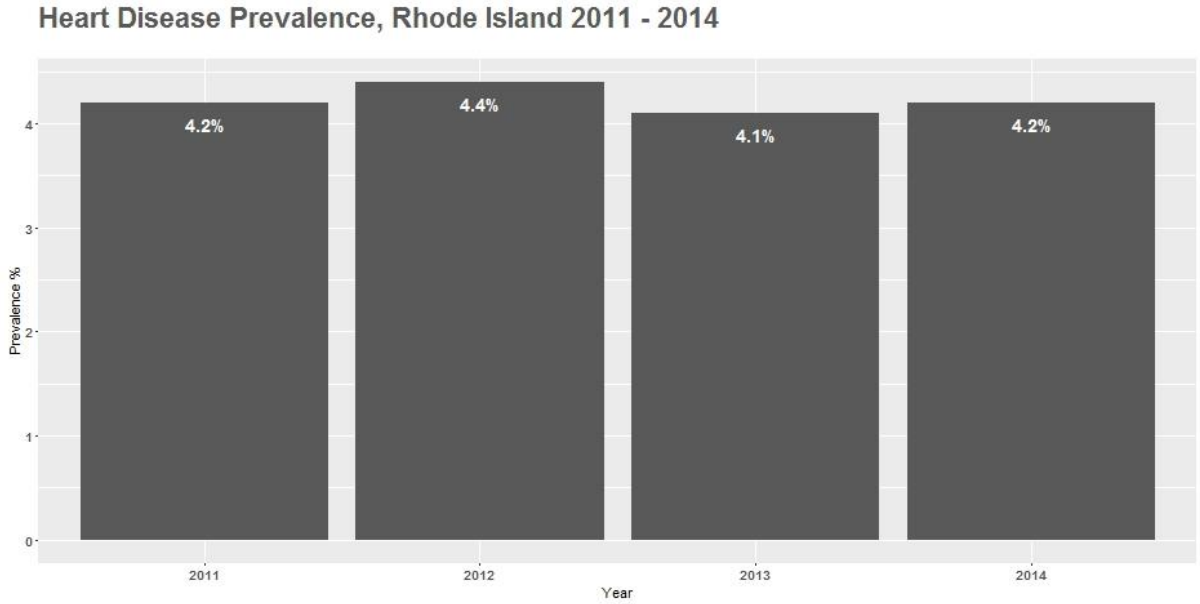
At-Risk Populations and Disparities

BRFSS data for heart disease, heart attacks and stroke all show an increased prevalence among males as compared to females. The rates of these conditions all continue to decrease as income and education levels increase. However, White, Non-Hispanic Rhode Islanders have the highest rate of coronary heart disease, while Black, Non-Hispanic Rhode Islanders have the highest rates of heart attacks and strokes[48].

Historic Trends

The rates of heart disease, heart attacks and stroke have all held fairly steady between 2011 and 2014[49].

Figure 31



[48] Centers for Disease Control and Prevention. (2015).
[49] Centers for Disease Control and Prevention. (2015).

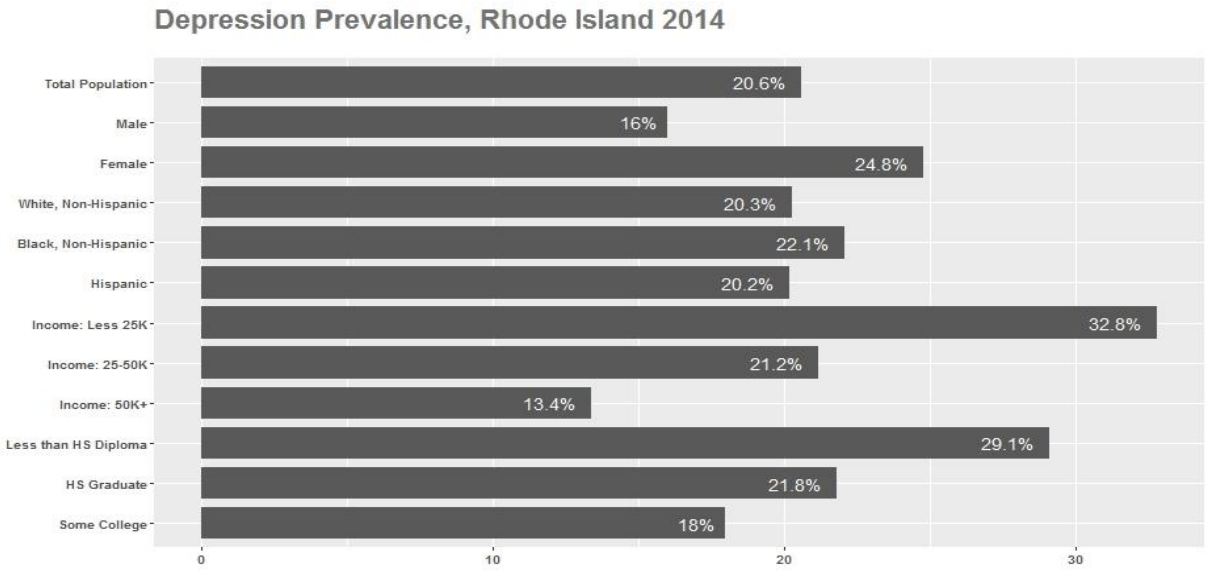
Depression: Health Focus Area 4

Definition
Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Major depression can lead to a complete sense of hopelessness as well. Depression impacts how individuals feel, think and behave, including impacting their overall well-being and participation in their healthcare.

Rhode Island's BRFSS measures for depression in multiple ways including: self-report of depression, if an individual was ever told he/she had a depressive disorder, dis-satisfaction with life, and the number of days in the past month in which mental health was not good. In addition, suicide rates and attempts are considered as proxy indicators of depression.
In this section we measure the prevalence of depression in Rhode Island based on respondents who were ever told he/she had a depressive disorder.

Prevalence
According to the BRFSS, in 2014 20.6% of Rhode Islanders reported that they had been diagnosed with depression. Depression is the third most highly reported chronic condition among Rhode Islanders across the lifespan and rates of depression in Rhode Island exceed the national average. [50]

Figure 32



At-Risk Populations and Disparities
According to these same data, adult females were more likely to report being diagnosed with depression than adult males (24.8% vs. 16%). At 22.1%, Black, non-Hispanic Rhode Islanders reported slightly higher rates of being diagnosed with depression than white, non-Hispanic (20.3%) and Hispanic (20.3%) residents.

[50] HealthFacts RI data

Historic Trends

Between 2011 and 2014, the overall prevalence of Rhode Islanders who have been diagnosed with depression bounced between 22% and just over 20%. Self-reported instances of being diagnosed with depression have followed a similar back and forth pattern among sub groups over the past four years.

Figure 33

Depression Prevalence 2011-2014

	2011	2012	2013	2014
Total Population	22.0	20.3	22.2	20.6
Male	17.77	15.66	16.48	16.04
Female	25.80	24.56	27.41	24.82
White, Non-Hispanic	22.41	19.73	22.38	20.28
Black, Non-Hispanic	21.40	21.35	19.93	22.08
Hispanic	19.50	22.86	20.97	20.23
Income: Less 25K	34.13	34.29	31.71	32.82
Income: 25-50K	22.52	18.76	23.60	21.21
Income: 50K+	15.28	12.82	14.96	13.42
Less than HS Diploma	24.37	31.53	31.71	29.09
HS Graduate	22.19	19.73	22.50	21.81
Some College	21.12	17.70	19.45	18.01

Children with Social and Emotional Disturbance: Health Focus Area 5

Definition

Rhode Island defines children with social and emotional disturbance as any person under the age of twenty-one (21) years who has been diagnosed as having an emotional, behavioral or mental disorder under the current edition of the Diagnostic and Statistical Manual or DC: 0-3. Furthermore this definition reflects that the disability has been ongoing for one year or more or has the potential of being ongoing for one year or more, the child is in need of multi-agency intervention, and the child is in an out-of-home placement or is at risk of placement because of the disability.[51]

Prevalence

According to the Rhode Island Executive Office of Health and Human Services Claims data, in State Fiscal Year (SFY) 2015, 22% (26,930) of children under age 19 enrolled in Medicaid/RIte Care had a mental health diagnosis, including but not limited to anxiety, alcohol/drug dependence, psychoses as well as depressive, mood, and personality disorders. Of those children with a mental health diagnosis, 29% were ages 6 and under, 34% were ages seven to 12, and 37% were ages 13 to 18.[52]

Disparities/Vulnerable Populations

The availability of, and access to, behavioral health treatment varies for children in Rhode Island. Currently, early childhood evidence-based practices, which can reduce the emergence of social and emotional disturbances in children, are funded through a federal grant and are predominantly available in targeted geographic areas. Only 8% of children/families served by

[51] Home and Placement-Based Services to Improve Outcomes for DCYF Children, Youth and Families, RFP #7550411, March 15, 2016.
[52]

the Maternal, Infant, Early Child Home Visiting Program resided outside of Rhode Island's 4 Core Cities (Central Falls, Pawtucket, Providence and Woonsocket).[53]

The Truven Health Analytics report found that 34% of children in Rhode Island were not able to access mental health services when needed. There were significant disparities between populations of children who were able to access mental health services when needed: 75% of African American and 74% of Hispanic children did not receive treatment when needed, as opposed to 17.2% of White children.

Historic Trends
In 2014, there were 2,744 hospitalizations of children with a primary diagnosis of mental disorder at Bradley, Butler, Hasbro Children's Hospital, Newport, and Memorial Hospitals, a 53% increase from 2005. Of the Rhode Island children hospitalized in 2014, 74% were ages 13 to 17, 50% had Medicaid/RIte Care coverage and 47% had commercial coverage, and 39% lived in one of the four core cities (where 33% of the child population lives).[54]

In Rhode Island between 2010 and 2014, there were 873 emergency department visits and 442 hospitalizations of youth ages 13-19 due to suicide attempts. Twenty-four children and youth under age 20 died due to suicide in Rhode Island between 2010 and 2014.The six Community Mental Health Organizations (CMHOs) in Rhode Island are the primary source of public mental health treatment services available in the state for children and adults. During 2015, 5,837 children under age 18 were treated at CMHOs, and 3,660 children were receiving treatment as of December 31, 2015.

Serious Mental Illness: Health Focus Area 6

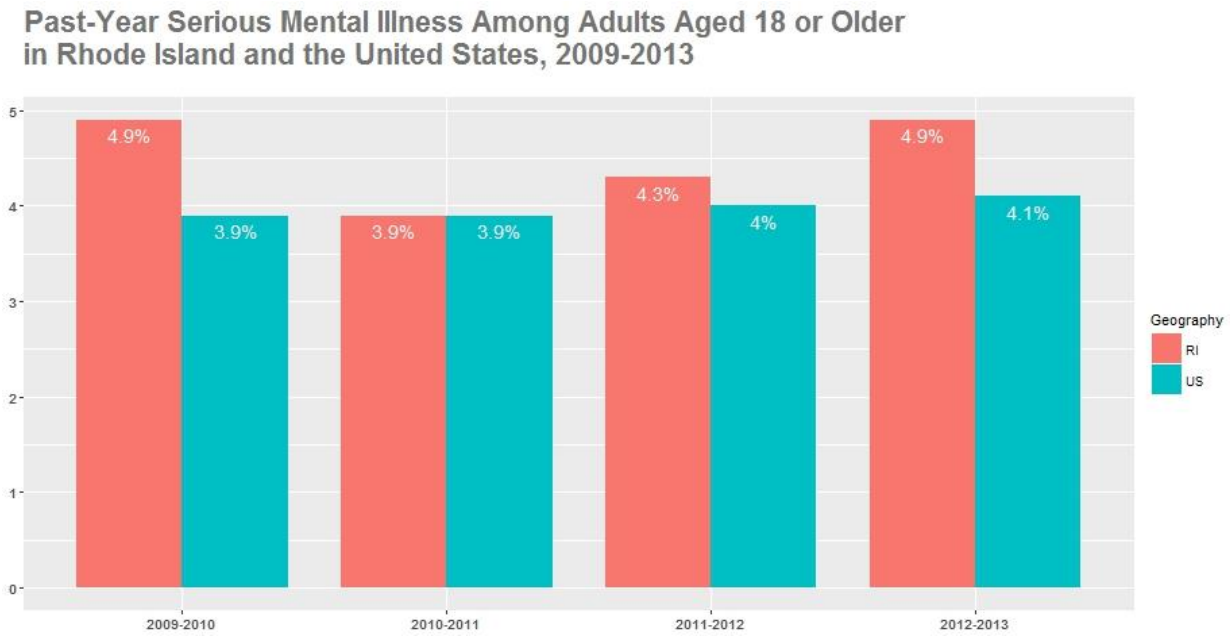
Definition
Serious Mental Illness (SMI) is a severe and/or persistent mental or emotional disorder in a person aged 18 years or older that seriously impairs his/her functioning relative to primary aspects of daily living such as personal relations, living arrangements, or employment. In this section, we measure the prevalence of serious mental illness in Rhode Island looking at the percentage of residents who have experienced a serious mental illness or major depressive episode in the past year based on clinical interviews and predictive modeling used by Substance Abuse and Mental Health Services Administration (SAMSHA) in its National Survey on Drug Use and Health (NSDUH).

Prevalence
Because of the small sample size of Rhode Islanders used in its survey, SAMSHA combined multiple years of data to estimate the prevalence of serious mental illness in Rhode Island. According to clinical interviews and predictive modeling generated by SAMSHA, over the course of 2012-2013, 4.9% of all Rhode Island adults had "experienced a serious mental illness within the year prior to being surveyed."[55] Among Rhode Islanders, rates of serious mental illness and rates of at least 1 major episode in the past year vary slightly by age range (see table X), but all rates are higher than the national average.

[53] Truven Health Analytics. (2015). *Rhode Island Behavioral Health Project:Supply Report.*
[54] The Rhode Island Kids Count Factbook, 2016
[55] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Rhode Island, 2014. HHS Publication No. SMA–15–4895RI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Figure 34

Indicators of Serious Mental Health Disorders Among Adults Aged 18 or Older: Rhode Island vs United States 2009-2013



At-Risk Populations and Disparities

According to a report issued by the Agency for Healthcare Research and Quality, individuals with serious mental illness often experience disparities in health care, specifically differences or gaps in care when compared with patient populations with a mental health diagnosis but without a diagnosis of SMI. Such disparities may be even more pronounced between certain groups of patients with SMI, differing by race, ethnicity, gender, economic disadvantage (including housing stability) and socioeconomic status, and geographic location (chiefly, rural versus urban residence). Disparities exist for individuals identifying as lesbian, gay, bisexual, and transgender (LGBT) and those who have difficulty communicating in English (because it is a second language) as well.[56]

In Rhode Island, one-third of individuals seeking services at an emergency shelter or transitional housing setting in 2014 reported having a mental health issue. More than half were assessed as having problems with alcohol and one-quarter as having problems with illicit drugs. In addition to behavioral health disorders, individuals who are homeless often have untreated chronic medical conditions. These co-morbidities result in high costs associated with ambulance transports, emergency room admissions, inpatient hospitalizations (including for mental health reasons), and interactions with the police.[57]

[56] Disparities Within Serious Mental Illness, Technical Brief Number 25, prepared for the Agency for Healthcare Research and Quality by RTI International – University of North Carolina Evidence-based Practices Center, May 2016

[57] Rhode Island Coalition for the Homeless. (2014). *Homeless Management Information System, Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), 2014.*

Opioid Use Disorders: Health Focus Area 7

Definition

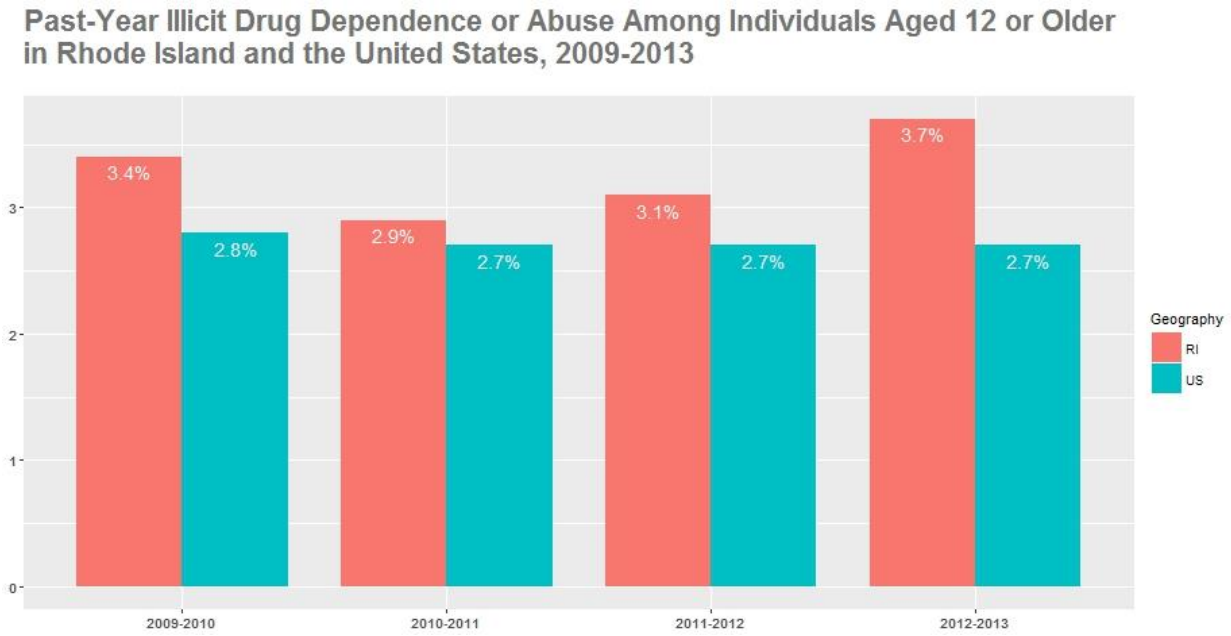
Opioid addiction (also called dependence) is a chronic brain disease that can develop with repeated daily exposure to opioids. It is characterized by the development of tolerance (the need for an increasingly higher dose to achieve the same effect) and withdrawal (an extremely painful condition that occurs when people try to stop usage abruptly). The natural progression of this disease leads to using greater amounts of drugs over time, which typically drives people to increasingly desperate and dangerous behaviors.[58] In this analysis, we measure the prevalence of Past-Year Illicit Drug Dependence or Abuse Among Individuals Aged 12 or Older in Rhode Island, based on National Survey on Drug Use and Health (NSDUH) data (2009–2013),[59] as well as Overdose-related death rates as reported by the Rhode Island Office of State Medical Examiner.

Prevalence

The opiate epidemic in Rhode Island can be categorized in two ways–addiction to prescription opiates and addiction to heroin. Illicit drug use is a significant concern in Rhode Island. According to data collected in the National Survey on Drug Use and Health (NSDUH), between 2012-2013, 3.7% of Rhode Islanders over the age of 12 were dependent on or abused drugs within the year before they were surveyed.

Figure 35

Past Year of Illicit Drug Dependence or Abuse Among Individuals Aged 12 or Older: Rhode Island vs National Average



Opiate drug addiction in Rhode Island, similar to many states throughout the country, is described as an "epidemic." The epidemic has grave consequences for Rhode Islanders: death

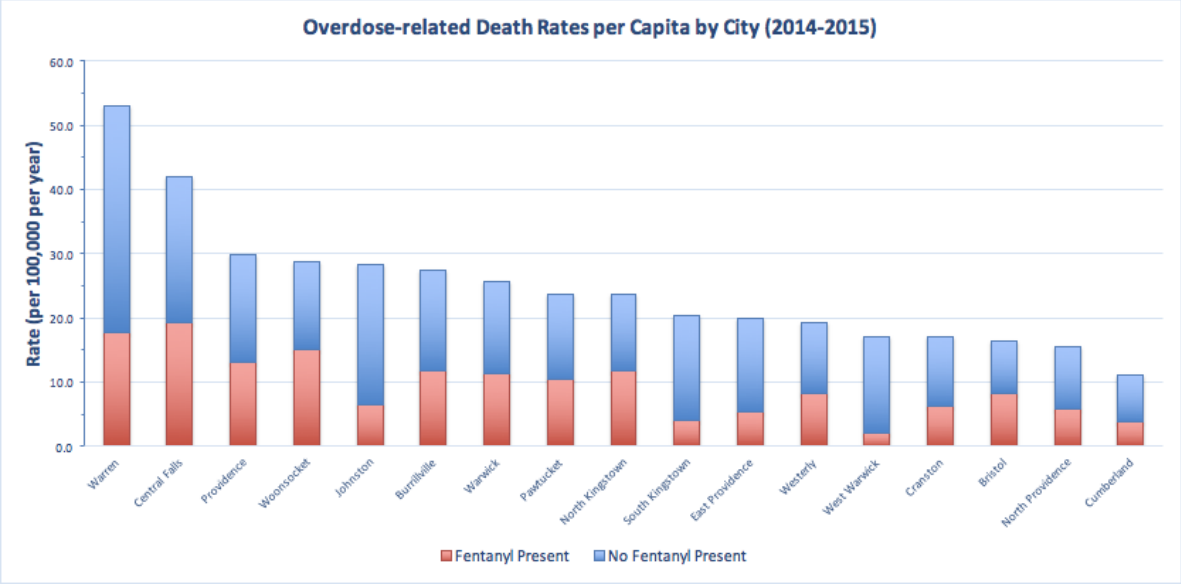
[58] Rhode Island Governor's Overdose Prevention and Intervention Task Force. (2015). *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic*.
[59] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

rate for all ages attributed to narcotics and hallucinogens more than doubled between 2011 and 2013. 239 Rhode Islanders died as a result of a drug overdose in 2014[60].

At-Risk Populations and Disparities

According to the Rhode Island State Medical Examiner's office, the highest rates of drug-related deaths in Rhode Island are (in order): Kent County, Providence County, Washington County, Newport, and Bristol.[61] According to the Opiate Task Force Report, reported death rates for 2014-2015 were high in Providence and in many surrounding towns and cities (e.g. in Warren, Central Falls, and southwestern Rhode Island).[62]

Figure 36



Historic Trends

Like many states across the country, Rhode Island has experienced an alarming increase in the abuse of opiates over the past ten years. In 2013, Rhode Island had one of the highest rates of illicit drug use in the nation, as well as the highest rate of drug overdose in New England.[63] According to a report issued by The Rhode Island Opiate Task Force, this recent increase in opiate abuse is directly related to a dramatic increase in the amount of opioids prescribed. The accessibility of opioid pain medications—such as Vicodin, Percocet, or OxyContin— often leads to the use of heroin, which has become much cheaper. Since 2002, rates of heroin addiction doubled and heroin-related overdose deaths nearly quadrupled. Adding to these challenges, benzodiazepines are increasingly available, and overdoses related to fentanyl-laced illicit drugs increased dramatically.[64]

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[60] Rhode Island Governor's Overdose Prevention and Intervention Task Force. (2015). *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic*.
[61] Rhode Island Hospital/Hasbro Children's Hospital Community Health Needs Assessment, September 30, 2013
[62] Rhode Island Governor's Overdose Prevention and Intervention Task Force. (2015). *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic*
[63] Rhode Island Governor's Overdose Prevention and Intervention Task Force. (2015). *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic*.
[64] Rhode Island Governor's Overdose Prevention and Intervention Task Force. (2015). *Rhode Island's Strategic Plan on Addiction and Overdose: Four Strategies to Alter the Course of an Epidemic*.

80% of overdose deaths in 2015 were involved illicit drug use, up from 67-70% in prior years.[65] In spite of the escalation of the problem and growing need for treatment, State funding for substance abuse services dropped from about $15.5 million to $5 million between 2007 and 2014.[66]

Other Notable Trends and Local Alignment

Community Health Needs Assessment Findings

Rhode Island's hospitals are currently preparing their 2016 Community Health Needs Assessments (CHNAs), which will build on the efforts and infrastructure created for the 2013 CHNAs. In 2013, as in 2016, a majority of the state's hospitals worked with the Hospital Association of Rhode Island (HARI) to conduct a statewide Community Health Needs Assessment.[67] The report drew on data from the BRFSS as well as secondary data on measures such as mortality rates, cancer statistics, communicable disease data, and social determinants of health (poverty, crime, education, etc.).[68]

These data sources were later compiled on a HARI sponsored website, RIhealthcarematters.org, to make the information easily available to the public. The website features not only data measures but also maps, resources, and tools for generating reports on a range of topics, from access to health insurance to the rate of violent crime. When available, data can be broken down by census tract, county, and zip code. The site also compares Rhode Island-specific data with Healthy People 2020 benchmarks to show the state's current status by using. The colors to show how the state or specific communities within the state rank when compared to other parts of the country. Red indicates a poor rank, yellow indicates fair performance, and green indicates a good rank.[69]

An outside contractor manages RIhealthcarematters.org to ensure the website reflects the most updated version of each data source.[70] Although HARI is still completing its 2016 CHNA, the RI Health Care Matters website provides a starting point for examining the most recent relevant surveillance data for the state. The figure below shows a sample of some measures from the Rhode Island Health Care Matters website that are relevant to the SIM Health Focus Areas:

[65] Opiate Task Force Report
[66] Truven Health Analytics. (2015c).
[67] Holleran Consulting. (2013). *Community Needs Assessment Final Report*.
[68] Holleran Consulting. (2013).
[69] Hospital Association of Rhode Island. (2016). *RI Healthcare Matters*. Retrieved from: www.rihealthcarematters.org/index.php?module=htmlpages&func=display&pid=5002.
[70] Expert interview with Hospital Association of Rhode Island, March 24, 2016.

Figure 37

CHNA Measures Relevant to SIM Health Focus Areas

	Statewide	Data Source	Disparity Data Available?	Measurement Period	Healthy People 2020 Target
Premature Death (years of potential life lost before age 75)	5,808 per 100,000 population	County health rankings	No	2010-2012	NA but "good" compared to other U.S. States
Adults who smoke	17.4%	BRFSS	Age, gender, Race/ethnicity	2013	Not met (12%)
Adolescent cigarette usage	8%	Youth Risk Behavior Surveillance System (YRBSS)	No	2013	NA
Adults with Diabetes	9.3%	BRFSS	Age, gender, Race/ethnicity	2013	NA but "good" compared to other U.S. States
Adults who are obese	27.3%	BRFSS	Age, gender, Race/ethnicity	2013	Met (30.5)
Age adjusted death rate due to stroke (Cerebrovascular Disease)	27.9 deaths per 100,000 population	Centers for Disease Control and Prevention (CDC)	Gender, Race/ethnicity	2012-2014	Met (34.8)
Poor Mental Health Days (average # of days mental health was "not good" in past 30 days)	3.6 days	County Health Rankings	No	2006-2012	NA but "fair" compared to other U.S. States

Informant Interview Findings

HARI's 2013 Community Health Needs Assessment also relied on a series of key informant surveys with 49 Rhode Islanders including elected officials, healthcare providers, health and human services experts, long-term care providers, representatives from the business community, and educators. When asked about the three top health issues they saw in their community, the three most cited issues were:

- *Access to Health Care/Uninsured/Underinsured (mentioned by 82% of respondents);*
- *Mental Health/Suicide (mentioned by 47% of respondents); and*
- *Overweight/Obesity (mentioned by 39% of respondents).*

Substance abuse/alcohol abuse, diabetes, and maternal/infant health were the next three most frequently mentioned health issues.

When asked about specific barriers to accessing health care, respondents listed these top areas of concern (please note that this work was completed before the full implementation of the Affordable Care Act and the expansion of Medicaid/availability of health insurance tax credits):

- *Lack of Health Insurance Coverage;*
- *Lack of Transportation; and*
- *Inability to Pay Out of Pocket Expenses.*

Survey respondents listed immigrants/refugees, the low-income/poor, the Hispanic/Latino population and Rhode Islanders with mental health needs as the most underserved populations in the state. Two focus groups with a total of 21 local behavioral health care experts focused entirely on mental health issues and resources within Rhode Island.[71] Participants listed these issues as their top behavioral health concerns:

- *Increased substance abuse (especially among adolescents);*
- *Co-occurring mental illness and substance abuse;*
- *Patients with complex conditions; and*
- *Relationship between mental and physical health.*

The behavioral health experts listed adolescents, the elderly, the homeless and non-English speakers as the populations that are most underserved when it comes to mental health services. Focus group participants also stressed the need to better integrate primary care and mental health, provide regular mental health screenings of patients with chronic conditions, and support existing partnerships with schools and community organizations. Participants advocated for a shift away from treatment plans that were led by payers to ones that are led by providers, noting that current restrictions prevent them from offering the best treatments for their patients.

Findings Aligned to SIM
When HARI combined this qualitative data with its other data sources about the health of Rhode Islanders, it noted that the research revealed a number of "overlapping health issues." The CHNA report highlights these issues as the most prominent concerns for Rhode Island:

- ***Access to Care***
  Stakeholders raised specific concerns about the ability of Rhode Island's uninsured/underinsured residents to access care. They also highlighted difficulties accessing some types of specialty care and a lack of bilingual providers.
- ***Mental Health Status***
  Rhode Islanders report a higher than average number of days in the past month when poor physical or mental health interfered with their ability to function. There is also an elevated rate of residents with a "depressive disorder." Stakeholders identified mental health as one of the state's key health issues, specifically stressing a lack of treatment options, which results in patients using the emergency room instead of more appropriate sources of care.
- ***Overweight and Obesity***
  At the time this report was written, 62.3% of Rhode Islanders were either overweight or obese. Data analyzed in the CHNA also indicates that Rhode Islanders exercise less than their peers in other states. Key stakeholders voiced their concerns about the relationship between obesity and chronic diseases such as diabetes.

Other Findings Not Currently Aligned to SIM
The following CHNA findings were thematic but do not directly relate to the current SIM Health Focus Areas, but are similar (e.g., substance abuse, other chronic diseases):

[71] Holleran Consulting. (2013).

- ***Alcohol Use***
  Data used in the CHNA report found a high density of liquor stores and higher reported rates of adult alcohol use when compared to national averages. Mental health professionals also discussed concerns about "co-occurring disorders with mental health issues and addiction."[72]
- ***Asthma***
  Rhode Island's rate of adults who ever received an asthma diagnosis and those who still struggle with asthma are higher than rates in other parts of the country. Children in Rhode Island also have elevated asthma rates.
- ***Breast Cancer Incidence***
  Rhode Island has higher rates of breast cancer than other parts of the country but death rates due to breast cancer are lower, indicating that patients might receive more effective treatment or earlier detection.

HARI published these findings in one document, the *Community Needs Assessment Final Report,* to offer a statewide perspective on the health of the state, but it also generated reports for each of its member hospitals, focusing on data specific to the needs of each medical center's service area. Lifespan Hospitals (Rhode Island Hospital, Bradley Hospital, The Miriam, Hasbro Children's Hospital and Newport Hospital) did not participate in the Hospital Association's CHNA process. The Community Health Needs Assessments for Lifespan hospitals focused on data specific to the service areas and priorities of Lifespan's medical centers. Community Health Needs Assessments conducted by Bradley and Hasbro Hospitals reported that "access to mental health services" was a significant health issues, as identified by respondents with members served by their hospitals.[73]

Moving Forward

For 2016, HARI is once again organizing a statewide assessment for its member hospitals. The new report includes findings from analyzing public health and utilization data. It also summarizes the results of "partner forums" with community partners and "focus groups" with health consumers. The final reports are scheduled to be approved by member hospitals this summer.[74] Lifespan is also in the process of completing its data analysis and collection for its 2016 CHNA report.

Specific Behavioral Health Findings

Inadequate access to behavioral health treatment is a commonly expressed concern in Rhode Island. Community Health Needs Assessments (CHNAs) conducted by the Hospital Association of Rhode Island (HARI) [75] and individual assessments conducted by Bradley and Hasbro Hospitals reported that "access to mental health services" was a significant health issue..[76]

The Hasbro CHNA identified significant community concern about "boarders," patients waiting in the emergency department for access to inpatient mental health services. Rhode Island Hospital has created a distinct location and protocol in the emergency department for treating psychiatric patients after recognizing the need for more psychiatric care in the emergency room setting. Through the development of crisis management programs, the provision of diversion services, and the creation of space for clinicians, patients and their families, the program made

[72] Holleran Consulting. (2013).
[73] Rhode Island Hospital/Hasbro Children's Hospital Community Health Needs Assessment, September 30, 2013
[74] Baker Tilly. (2015). *The HARI 2015-16 CHNA approach and methods*.
[75] Rhode Island Hospital/Hasbro Children's Hospital Community Health Needs Assessment, September 30, 2013
[76] Rhode Island Hospital/Hasbro Children's Hospital Community Health Needs Assessment, September 30, 2013

significant progress in reducing the number of boarders in the emergency departments (EDs) at Rhode Island Hospital and Hasbro Children's Hospital. In 2012, the program had nearly 8,200 adult patient encounters and 540 pediatric patient encounters.[77]

Overarching Inequalities and At-Risk Populations

In 2015, The Rhode Island Commission for Health Advocacy and Equity (CHAE) Legislative Report provided an assessment of health disparities, or differences in health between population groups in our state. The report noted differences in health outcomes. For example, adults with disabilities (compared to those who do not have disabilities) have significantly higher rates of obesity, diabetes, high blood pressure, and heart disease prevalence; and those with lower incomes and educational attainment have higher rates of diabetes and heart disease than those with higher income and educational attainment. Health disparities are particularly problematic for those with characteristics linked to discrimination or exclusion. A health disparity related to a social, economic, and/or environmental disadvantage is called a health inequality. The aspirational goal of health equity means attaining the highest level of health for all people and valuing everyone equally. To achieve health equity, efforts must be made to address avoidable inequalities and injustices.

Homeless Community

The homeless community was not discussed in the 2015 Rhode Island Commission for Health Advocacy and Equity Legislative Report. Individuals who are homeless consume a disproportionate amount of Rhode Island's resources – this is consistent with the national landscape. One-third of individuals seeking services at an emergency shelter or transitional housing setting in 2014 reported having a mental health issue, more than half were assessed as having problems with alcohol, and one-quarter as having problems with illicit drugs. In addition to behavioral health disorders, individuals who are homeless often have untreated chronic medical conditions. These co-morbidities result in high costs associated with ambulance transports, emergency room admissions, inpatient hospitalizations (including for mental health reasons), and interactions with the police.[78]

Over a third of the homeless in Rhode Island spend a majority of nights sleeping on streets, in parks, in vehicles, and in other places not meant for habitation instead of sleeping in a shelter. Since these individuals have clear, existing vulnerabilities, living outside poses additional threats to safety, health, and well-being. Not only are these individuals disproportionately at risk of being physically attacked, they are also exposed to harsh weather conditions that pose very real threats to life and health.[79] The cost of homelessness in Rhode Island goes beyond the health and well-being of individuals - the utilization of expensive emergency medical and mental health services in this population is vastly higher than that of the general population. According to a 2012 report published by the Special State Commission to Study Emergency Department Diversion, the average cost of an emergency department visit in Rhode Island is $2,101, and the average cost for an Emergency Medical Service run is $580 in Providence.[80] A report by the Office of the Health Insurance Commissioner in 2010 listed the average cost of an in-patient hospitalization to be $3,238 per day.[81]

A study of the rates of service utilization reported by 885 homeless individuals (1,808 emergency department visits, 864 ambulance rides, and 698 in-patient hospitalizations) over

[77] Rhode Island Hospital/Hasbro Children's Hospital Community Health Needs Assessment, September 30, 2013.
[78] Rhode Island Coalition for the Homeless. (2014). *Homeless Management Information System, Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), 2014.*
[79] Bunzli, L. and Hirsch, E. (2015). *Zero 2016 Rhode Island: A Report on the State of Homelessness*. Rhode Island Coalition for the Homeless.
[80] Special Senate Commission to Study Rhode Island Emergency Department Room Diversion. (2012). *Findings and Recommendations.*
[81] Office of the Health Insurance Commissioner. (2010). *Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island.*

the most-recent 6-month period yielded an estimated cost for medical treatment exceeding $6.5 million.[82] There is opportunity to significantly reduce medical expenses and improve healthcare outcomes for this population. Providing permanent housing and supports to assist people in stabilizing their health and accessing preventive treatment has been shown to be considerably less costly, as individuals' utilization of emergency services decreases significantly once housed. The Special State Commission to Study Emergency Department Diversion cited the average annual savings per person to be $8,839 if people were placed in a Housing First program with a high level of support."[83] Though none of the SIM interventions specifically address homelessness, the creation of a SDOH measure set could include financial resource strain (that includes financial/housing hardship) which would uncover risk factors for homelessness

Other Health Inequalities

Other underserved populations include LGBTQ, non-English speaking, persons with intellectual and developmental disabilities (IDD), autism, brain injuries, and youth with substance use disorders – these populations are underserved partially due to the lack of trained providers and specialty targeted interventions. Additionally, the lack of data on these groups prevents consistent surveillance of disparities. The 2015 CHAE report highlighted three factors that contributed to the limitations outlined in the report:

1. *Non-standardized reporting of the social determinants across health outcomes.*
2. *Exclusion of important social categories from some data collection tools (for example, sexual orientation).*
3. *Exclusion of racial and ethnic populations, such as Native American and Southeast Asians, due to small population and sample size.*

Strategies for addressing these issues, such as the development of a SDOH measures set will begin to address the limitations noted by the CHAE in the measurement and reporting of health disparities.

[82] Bunzli, L. and Hirsch, E. (2015).
[83] Bunzli, L. and Hirsch, E. (2015).

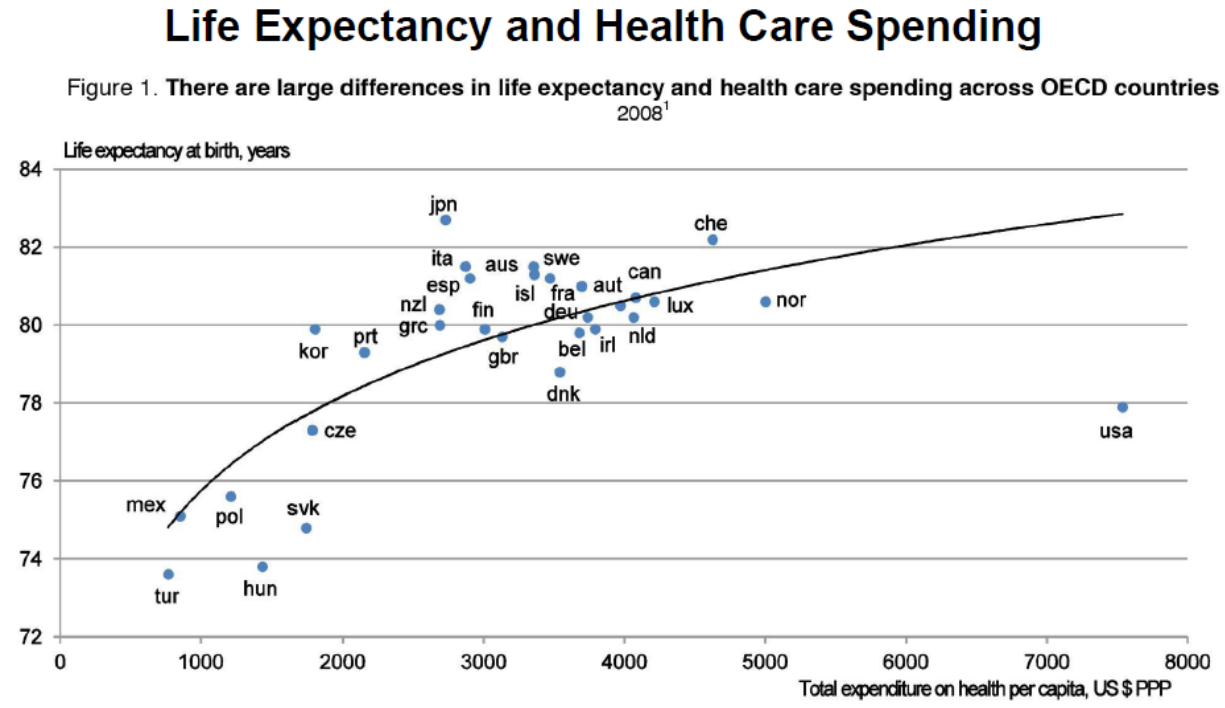
Current State and Future Goals

Within Rhode Island, two significant priorities related to health improvement are healthcare transformation and population health. This section of the Integrated Population Health Plan (IPHP) describes the general landscape related to these two health improvement priorities and the intersections with the State Innovation Model (SIM) Test Grant. Additionally, strategies and goals for improving population health related to the health focus areas are described within this section.

Healthcare Transformation

The cost of health care, including behavioral healthcare, is growing at an unsustainable rate in Rhode Island and across the United States. Smarter spending and reduced costs are a focus of the Centers for Medicaid and Medicare Services (CMS) with the SIM initiative and Quality Payment Program (QPP). Both efforts focus on using incentives, care management, and information sharing as mechanisms to achieve smarter spending, better care, and healthier people. The figure below highlights an anomaly related to healthcare spending and the United States. While the United States spends a higher amount on healthcare when compared to other developed countries, the lower life expectancy within the United States is a significant outlier to the trend.

Figure 38



Organisation for Economic Co-operation and Development (OECD)

Source: OECD 2010, "Health care systems: Getting more value for money", *OECD Economics Department Policy Notes, No. 2.*

Rhode Island ranked 7th for healthcare costs in the United States during 2009, with per-capita expenses of $8,309 compared to the national average of $6,815. In 2013, healthcare costs rose to $8,628 per-capita. Rhode Island's current healthcare system is not built to achieve the socially desirable results of improved physical and behavioral health for the state's residents, nor is the system financially sustainable. Because of these factors and other factors listed within the Rhode Island SIM Operational Plan, Rhode Island's payment reform initiatives address spending and improving population health.

SIM-Related Transformation Support

As described in the Operational Plan, payment reform is currently underway in Rhode Island, including the transition from volume-based to value-based care. Investments made through SIM will aid in the adoption of value-based payments. Rhode Island is using SIM to institutionalize a multi-sectoral collaborative that is committed to an integrated approach to improving the physical and behavioral health needs of Rhode Islanders by moving from a fee-for-service healthcare system to one based on value that addresses the social and environmental determinants of health. By providing the support to the healthcare providers and patients making their way through this new healthcare system, SIM helps to ensure the system operates as effectively as possible.

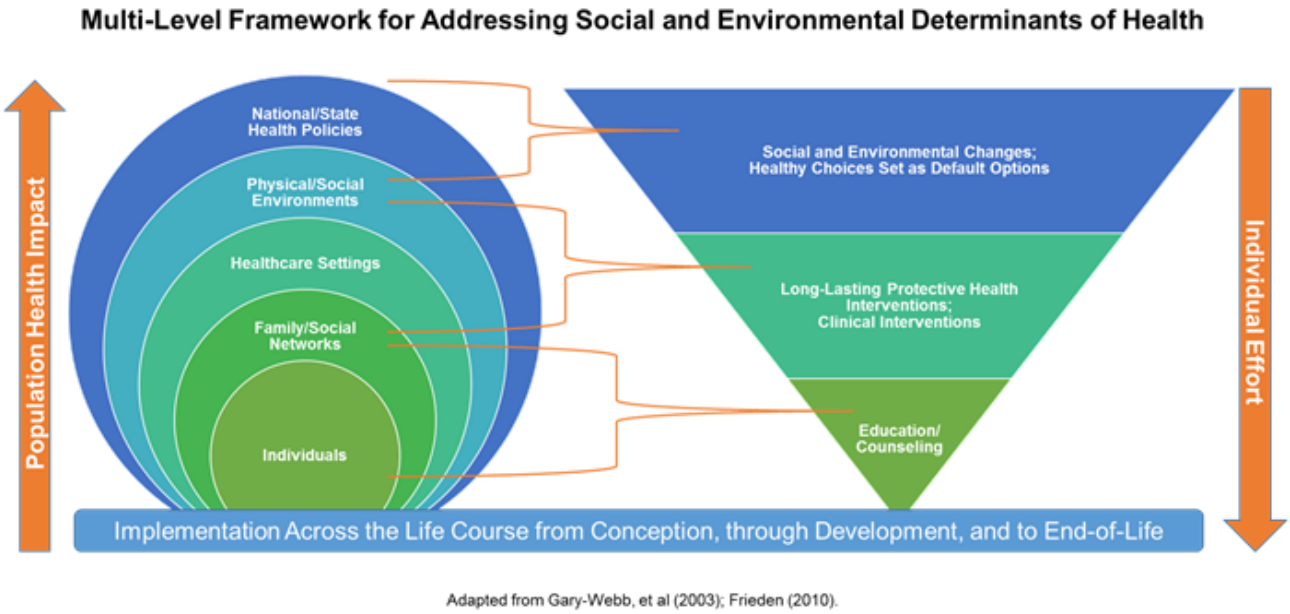
This approach to transformation also translates to population health improvement. Through SIM, public and private entities identified, assessed, shared, and aligned strategic goals and initiatives. The development of the health focus areas is one example where SIM leveraged the opportunity to link transformation efforts with population health improvements. SIM and other entities, such as the Office of the Health Insurance Commissioner, are building a population health improvement model into the Rhode Island healthcare delivery system. These ongoing efforts will require the commitment and cohesive policy making of a wide range of actors. The SIM support for system-wide adoption of the transformation efforts in Rhode Island will provide a means through which a common agenda and overarching alignment can continue to occur.

Population Health Improvement

Continued efforts to address the social and environmental determinants of health, across the life course, are needed to truly improve population health. While genetics and healthcare are important factors that can determine one's health outcomes, the majority of this determination is made by the collective effects from social, behavioral, and environmental factors. The figure below depicts a multi-level framework for addressing these latter determinants using a life course approach, and the alignment with the health impact pyramid.

Health-related behaviors, the receipt of recommended healthcare, and overall wellness occur in contexts. Such contexts are embedded in family and social networks, healthcare settings such as provider practices, and the physical and social environments. As individuals navigate these various contexts, they may be exposed to differential levels of toxic exposures and stressful experiences that shape the kinds of choices they [can] make. These choices ultimately impact their health and collectively determine the distribution of health and wellness across the entire population.

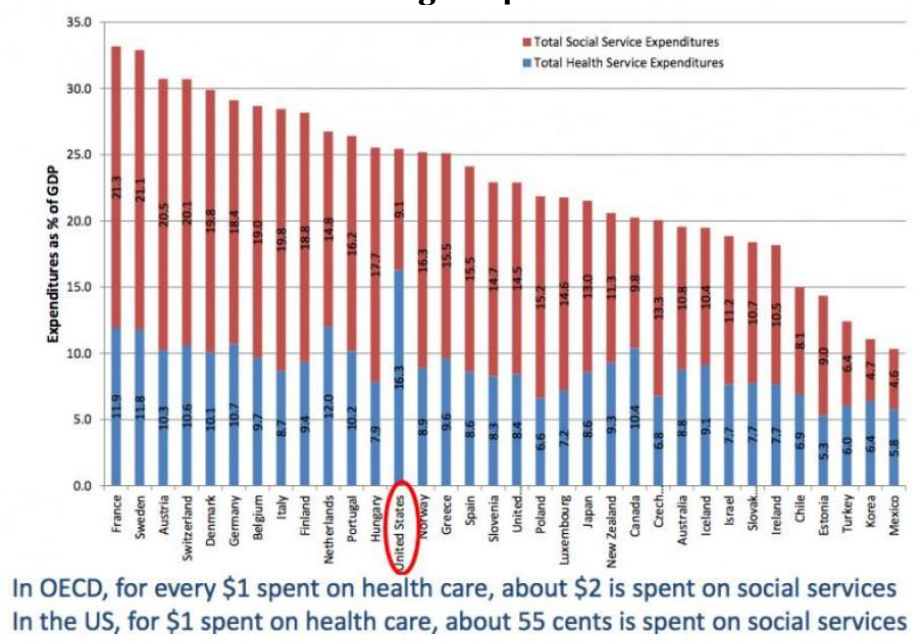
Figure 39



Adapted from Gary-Webb, et al (2003); Frieden (2010).

The development of an engaging health system, comprised of inclusive partnerships and multi-sector collaboration, is necessary to achieve larger impacts on population health. This health system can address the contexts that ultimately shape the population's health by expanding efforts to address social service, education, housing, and economic needs of the Rhode Island community. The figure below shows that for every dollar spent on healthcare in the United States, approximately 55 cents is spent on the social services aspect of our health system. This is approximately a quarter of what other developed countries spend on social services, many of which have better overall life expectancy.

Figure 40



http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/19/the-two-most-important-numbers-in-american-health-care/

SIM-Related Population Health Planning Support

The Rhode Island SIM Test Grant provided the initial infrastructure to begin development of a State Health Plan for Rhode Island. This IPHP, embedded within the SIM Operational Plan, serves as the first iteration of what will ultimately become the State Health Plan. The Rhode Island Department of Health (RIDOH) had already begun development of a population health goal-driven strategic plan based upon *Healthy People 2020* and this information served as an underlying framework for the SIM IPHP. In the assembly of the IPHP, a variety of documents were located, reviewed, and incorporated into the "assessment" portion of the IPHP (i.e., SIM-required sections one—seven). This section of the plan describes the overall health burden in the state for the seven focus areas and was created using source documents such as the State Healthcare Innovation Plan (SHIP), the 2014 Health Assessment and Improvement Plan, Community Health Assessments, and the 2015 Statewide Health Inventory. We consulted scholarly articles, program interviews, and various data sources and held several public forums to gain input on the development of and progress made with respect to the IPHP. The result of this work was the April 30, 2016 Draft SIM IPHP. This current iteration of the SIM IPHP, dated May 31, 2016 includes alignment with the Draft RIDOH Strategic Plan and the SIM Operational Plan.

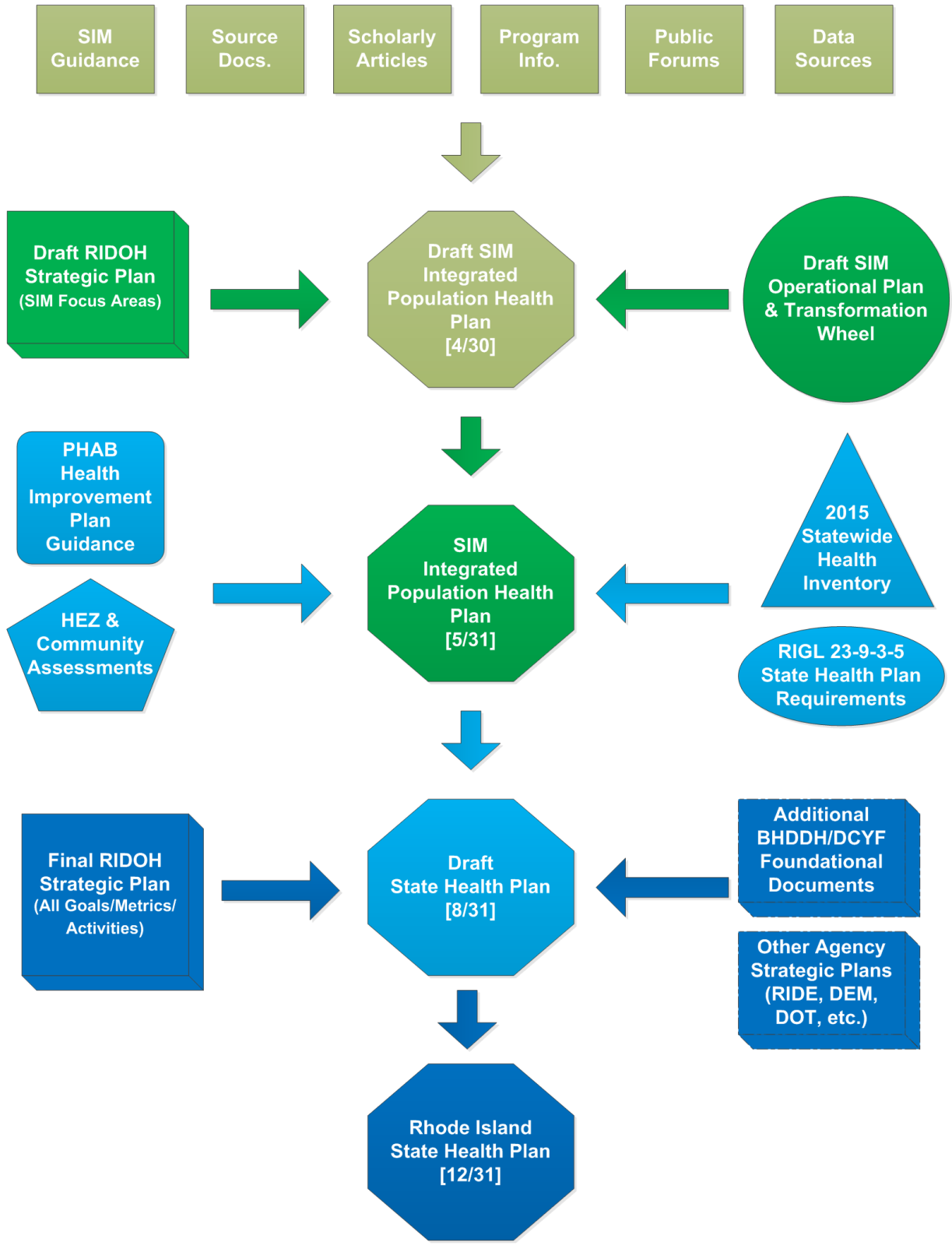
Ongoing IPHP Alignment

Going beyond the requirements for the SIM Operational Plan, Rhode Island will work to continue to build upon the IPHP to create an overall Rhode Island State Health Plan. The goal is to have one document that serves as the primary source for all population health planning in the state. To do this, two iterative steps have been outlined. First, we will include additional planning requirements to meet the mandates of the Public Health Accreditation Board and the Rhode Island Access to Medical Technology Innovation Act. This integration will include an ongoing Community Health Assessment, Health Improvement Plan, and State Health Plan. During this phase, we will align the updated Community Health Needs Assessments from the Hospital Association of Rhode Island as well as the Health Equity Zone Community Assessments with the IPHP, using them as case studies, health burden validation, and noted gaps in population health planning.

The second step is to expand the IPHP to all 15 population health goals and all 11 health focus areas from the original submitted SIM request for funding. At that time, we can include any additional strategies, goals, or source documents from RIDOH, the Department of Behavioral Health, Developmental Disabilities, and Hospitals, or the Department of Children, Youth, and Families. Metrics and measures will be in full alignment at this time. Lastly, we can include alignment with initiatives, activities, and interventions from other non-health-based agencies, such as transportation, education, environmental management, in order to create a robust State Health Plan for Integrated Population Health, focused on both healthcare transformation and addressing the social and environmental determinants of health. This will be a living document and updated to meet all cascading requirements. The figure on the next page depicts the entire planned alignment process for population health planning.

Figure 41

Intended State Health Plan Alignment Process



Population Health Strategies, Goals, and Metrics

Rhode Island's SIM Theory of Change focuses specifically on beginning to address the social and environmental determinants of health and the priorities of RIDOH guided the development of the population health key strategies and goals included in this plan. Those strategies and goals included in this plan address the needs of the seven health focus areas identified for SIM. In actuality, these same strategic priorities inform and apply to many of the SIM components, such as Community Health Teams, Patient Empowerment, and Practice Transformation. The three leading priorities for RIDOH which are the basis for the Draft RIDOH Strategic Plan that informed this work include:

- *Address the social and environmental determinants of health in Rhode Island;*
- *Eliminate disparities of health in Rhode Island and promote health equity; and*
- *Ensure access to quality health service for Rhode Islanders, including our vulnerable populations.*

Population Health Strategies

To drive both the SIM Theory of Change and population health priorities forward, we included a set of seven strategies within the IPHP. These seven strategies reflect a recommended pathway for achieving improved health within the context of the Triple Aim. The seven strategies for improving population health are as follows:

Figure 42

Population Health Goals and Key Metrics

We adopted population health goals to align these strategies to the seven SIM health focus areas. Specific key metrics within each goal reflect the specific health focus areas of SIM more than the broader goals across agencies. We adopted the following goals and key metrics to inform SIM and non-SIM population health efforts:

Table 13: Population Health Goals

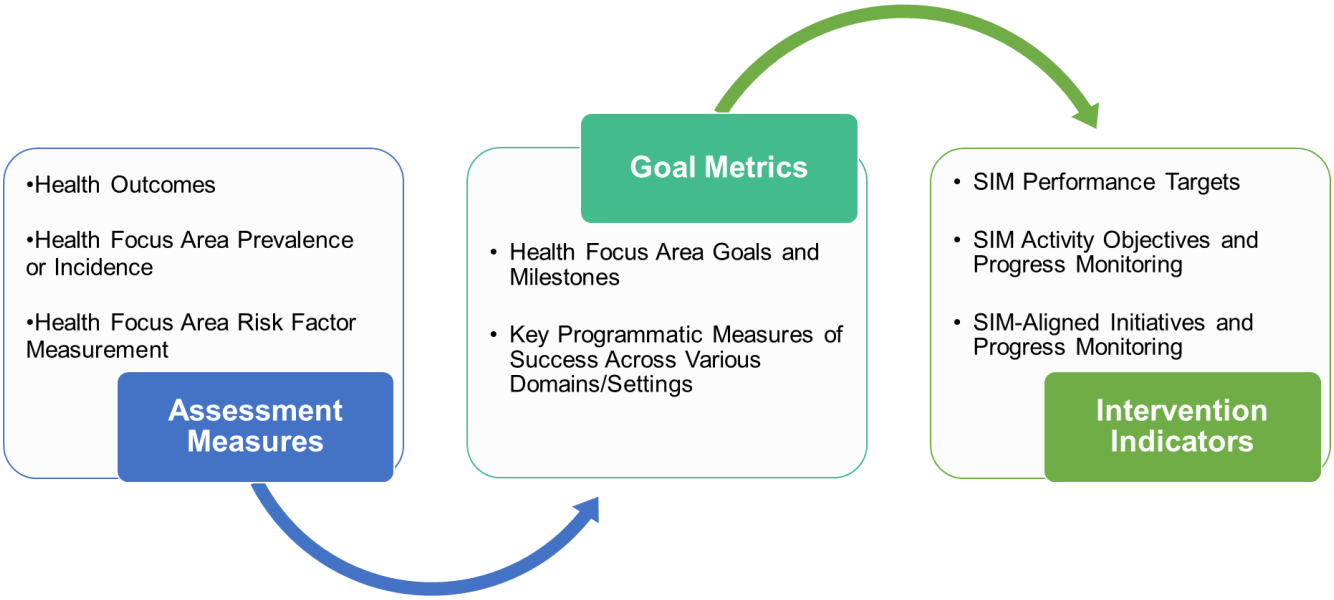
Goals	Key Metrics	Alignment	Data Source
Strategy: Promote healthy living for all through all stages of life.			
• Reduce obesity in children, teens, and adults.	Reduce the proportion of Rhode Islander adults who are obese from 27% to 24% by 2020.	Healthy People 2020	RIDOH
	Reduce the proportion of Rhode Island high schools students who are obese from 12% to 10.8% by 2020.	Healthy People 2020	RIDOH
	Increase the proportion of Rhode Islanders that participate in physical activity within the past 30 days from 77.5% to 85% by 2020.	Healthy People 2020	RIDOH
• Reduce chronic illness, such as diabetes.	Increase the proportion of persons with diabetes with an HbA1c value greater than 8% from X% to Y% by 2021.	Healthy People 2020 | SIM Aligned Measure Set	RIDOH
	Increase the number of people with pre-diabetes and/or at-risk for diabetes who are trying to lost weight from 50% to 55% by 2020.	TBD	RIDOH
	Heart disease metrics in development.	TBD	RIDOH
• Promote senior health to support independent living.	Stroke metrics in development.	TBD	TBD
Strategy: Ensure access to safe food, water, and healthy environments in all communities.			
• Reduce environmental toxic substances.	Reduce cigarette smoking among Rhode Island adults from 16.3% to 12.0% by 2020.	Healthy People 2020	RIDOH
	Reduce the proportion of Rhode Island adults exposed to second-hand smoke in the home from 7.8% to 5.0% percent by 2020.	Healthy People 2020	RIDOH
Strategy: Promote a comprehensive health system that a person can navigate, access, and afford.			
• Improve access to care, including physical, oral, and behavioral health.	Serious mental illness metrics in development.	TBD	TBD
	Children with social and emotional disturbance metrics in development.	TBD	TBD
	Depression metrics in development.	TBD	TBD
Strategy: Prevent, investigate, control, and eliminate health hazards and emergent threats.			
• Reduce substance abuse.	Opioid use disorder metrics in development.	TBD	TBD
Strategy: Analyze and communicate data to improve the public's health.			
• Encourage health information technology adoption among healthcare providers as a means for data collection and quality improvement.	HIT adoption metrics in development.	TBD	TBD
• Enhance and develop public health data sets to support population health surveillance and action.	Population health data set metrics in development.	TBD	TBD
• Develop and implement standards for data collection to improve data reliability and usability.	Data standards metrics in development.	TBD	TBD

Measure and Metric Alignment Process

We have established a process to fully define all measures and metrics for the SIM initiative and the SIM IPHP. We are coordinating measure identification, alignment, and in some cases, development, with the SIM Measure Alignment, Technology Reporting, and Population Health Workgroups to ensure measure definitions are consistent and standardized across sectors, collection systems, best practices, and categories of measures to avoid duplication, reduce administrative burden on providers and other community inputs, and maximize comparisons between data sets. *For a full list of **Assessment Measures and Additional Selection Criteria**, please see **Attachment I.*** The following categories of measurements have been identified, including specific organization of measures related to the SIM project:

Figure 43

Measure Alignment Categorization



Measure Selection

We are utilizing a standardized process to select measures for inclusion within the IPHP or for aligning measures in which there are multiple options for selection. To get a better picture of the health issues, we are considering a composite of metrics around surrounding goals, especially when evaluating improvements in sub-sets of the population or across different settings in which improvement may differ. By doing this, a full representation of measures across the integrated population health continuum can assist in informed decision-making and policy development. Once that is completed, we are using the following criteria, in consultation with guidance from CMS and the National Quality Forum, in measure determination with representatives of the various workgroups:

Table 14: Population Health Measure Selection Criteria

Criteria	Description
• *Magnitude of the issue (high burden)*	High prevalence of health outcome (number or percent of Rhode Islanders or population of interest affected).
• *Severity of the issue*	Risk of morbidity or mortality associated with the issue.
• *Magnitude of health disparities and impact on vulnerable population*	Size of the disparity between socio-demographic groups; Differential impact on children, families living in poverty, individuals with disabilities.
• *Comparison with benchmarks (national, other states)*	Compared to US overall, other states similar in demographic profile.
• *Trends*	Extent to which issue has been getting worse in recent years.
• *Impact on healthcare costs—total costs*	Contribution of the health issue to healthcare costs for all payers—total costs.
• *Impact on employment and productivity*	Impact of health issue on person's ability to and keep employment.
• *Preventability of health issue*	Research evidence suggests that health issue largely caused by health behaviors, community environment and/or other potentially modifiable factors (other than genetic or biological characteristics) that can be addressed by programs, policies, and/or interventions.
• *Availability of evidence-based strategies*	Evidence of population based strategies.
• *Ability to track progress*	Data systems available (or will be available) to track issue and impact of strategies implemented.
• *Alignment with other SIM measures*	Related/similar to other "core measures" from SIM measures alignment.
• *Strategies available to link "whole-person" care providers with community-based prevention efforts*	Evidenced based strategies/tools/models are available for "whole-person" care providers to connect patients with community-based prevention/intervention programs.
• *Data source fitness*	The extent to which, among a myriad of data sources, a most relevant and reliable data collection method and sample size can be determined.

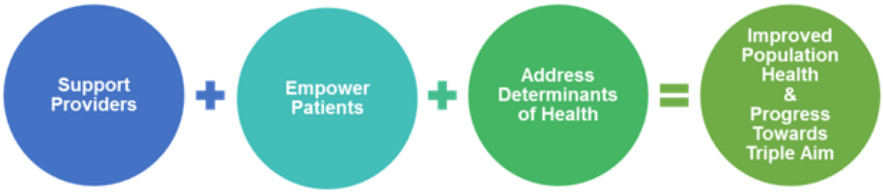
Existing and Planned Interventions

Aligning Interventions to SIM

Across the various agencies participating within our Rhode Island SIM Test Grant, many existing interventions can be aligned to our planned investments through SIM. In order to identify and align existing and planned interventions appropriately, we conducted an internal review of our programs, as well as conducted key informant interviews with staff who work on the seven health focus areas described in our Integrated Population Health Plan (IPHP). When identifying our existing interventions, we used our SIM Theory of Change to guide us. If any intervention or program supported providers, empowered patients, or addressed determinants of health, we included them. Below is a graphical depiction of our thinking,

Figure 44

SIM: The Rhode Island Context

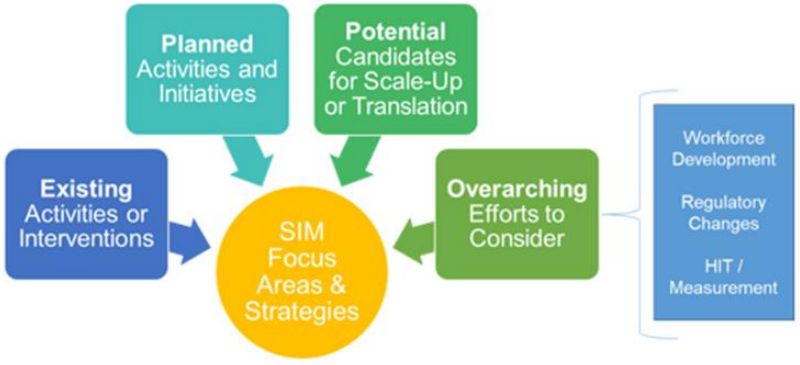


Rhode Island was awarded a total of 20 million dollars to catalyze additional transformation beyond the current efforts to move from volume to value within our healthcare system.

The IPHP's first major initiative is to align existing state and local programs with the new SIM investments. By coordinating new investments with ongoing and planned activities, we can ensure that resources are allocated appropriately and optimally to meet the needs of communities in Rhode Island. The following categorization was used when aligning our existing interventions to our SIM investments

Figure 45

Intervention Alignment to SIM Investments



For the Integrated Population Health Plan, aligning activities and interventions to the major SIM investments assists Rhode Island in sustainability planning and maximizes the opportunities for collaboration across the integrated physical and behavioral health continuum.

Abbreviated SIM Component Table
Below is a listing of the SIM investments with abbreviated definitions that were used with our partners when aligning interventions. For the full and complete description, please see the SIM Component Summary Table within the SIM Operational Plan.

Table 15: Abbreviated SIM Component Table

Investment	Abbreviated Description
Community Health Teams	Community health teams (CHTs) currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs improve population health by addressing social, behavioral, and environmental needs. Our SIM-funded teams will also support providers in transitioning to value-based systems of care; and help transform primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures
Child Psychiatry Access Program	The Pediatric Psychiatry Referral Consultation project will establish a children's mental health consultation team to support pediatricians and other primary care doctors serving children and adolescents with mental health conditions. The Access Program is designed to assist the pediatricians and other physicians to treat children with behavioral and mental health needs in a way that is preventive and responsive to a patient's immediate circumstances
PCMH Kids	PCMH-Kids builds off of the successes of Care Transformation Collaborative in Rhode Island (CTC-RI), the adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of primary care practices in Rhode Island to children. SIM funding for PCMH-Kids will include support for practice facilitation and coaching, practice assistance with reporting and analyzing data, and overall program evaluation.
SBIRT for PCPs	Rhode Island seeks to decrease the use of tobacco, alcohol and other drugs using the Screening, Brief Intervention and Referral to Treatment (SBIRT) grant to offer, over a five years, alcohol, drug and tobacco screening to 250,000 adults. As needed, referrals will be made to brief interventions or treatment. Priority populations are individuals living in designated high need areas and persons leaving Department of Corrections' facilities.
Integrated Behavioral Health Program for PCPs	The Rhode Island SIM Test Grant will fund a qualified provider with experience and skill in helping primary care practices, representing multiple payers, to integrate behavioral health care into their clinical work. The qualified provider will have expertise facilitating within primary care practices: 1) depression, anxiety and substance use screening; 2) collaboration of behavioral health specialty staff with nursing/physician personnel; 3) use of behavioral health subject-matter expert(s) to support training and development efforts; and 4) development of knowledge about appropriate measurement and quality assurance activities.
Care Management Dashboards for CMHCs	The SIM Test Grant will fund a real-time communication system between Rhode Island hospital providers and CMHCs, mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. An electronic dashboard will deliver real-time information to the CMHCs when their consumers have a hospital emergency department or inpatient encounter. This effort will support targeted, clinical interventions, improve care coordination and reduce re-admissions.
Provider Coaching Program for CMHCs	Another behavioral health investment will be provider coaching. Rhode Island's publicly funded Community Mental Health Centers (CMHCs) are "health homes" for persons with serious mental illnesses. SIM Test Grant funds will be used to support an expert coaching program to help CMHCs improve their effectiveness in addressing consumers' health care needs. Expert coaches will help CMHC staff: 1) improve clinical practices, such as connecting more effectively with primary care providers; 2) learn health information technology uses and benefits; 3) collect and measure data; and 4) strengthen quality improvement practices.
Healthcare Quality Measurement and Reporting Feedback System	This system will help providers "enter data once and analyze many times" to improve the quality of care for patients and drive improvement in provider practices by giving feedback to providers, and organization about performance based on quality measures; produce more valuable and accurate quality measurements using data from the entire care continuum; leverage centralized analytic expertise to drive improvements in population health; reduce the duplicate reporting burden with a common platform for reporting; publically report quality measurements in order to provide transparency and support patient engagement; and use existing databases.
Integrated Health and Human Services Data Ecosystem	Rhode Island lacks a modern system for integrating person-level information across our agencies and then turning that holistic information into action. While EOHHS has built a data warehouse that stores many different sources of data–in addition to separate data sets that live within each agency–there is limited capacity to first connect and then share those linked data, either at the person level or in the aggregate. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources. Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data.
Statewide Common	The provider directory is a database with a web-based tool that allows a staff team to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers. This organization hierarchy is unique and essential

Provider Directory	to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans.
HealthFacts RI	The Rhode Island SIM Test Grant is investing funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named "HealthFacts RI." HealthFacts RI will ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. It will also provide state agencies and policy makers with the information needed to improve the value of healthcare for Rhode Island residents and will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities.
Patient Engagement Tools	In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest funds to provide patients access to tools that increase their involvement in their own care, including creating the infrastructure to allow patients to more easily share their advanced care directives and healthcare proxies with their providers; developing patient engagement tools such as health risk assessments; and implementing tools that measure consumer satisfaction as well as behavior change readiness.
Advanced Illness Care Initiative	We know that patients and providers both avoid discussions about end-of-life planning, leading to unwanted medical care and family distress. SIM will fund Advance Care Planning Discussion trainings, to support providers in carrying out patient engagement activities in the event of advanced illness. The program will promote effective collaboration between patients, families, and providers in making healthcare decisions; improve health literacy among patients and their families; and provide opportunities for participants to complete advance directives.
Workforce Development	Development of the healthcare and overall health system workforce to best adapt to a changing payment system, adopt practice transformation efforts, and provide whole-person care consistent with achieving population health outcomes. This includes the ability to utilize health information technology and data. Bi-directional integration of physical and behavioral health is also of focus.
Measure Development / Alignment	Quality measurement and improvement are integral components of value-based contracting. As value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, between June 2015 and March 2016, the Measure Alignment Workgroup created by the SIM Steering Committee created an aligned measure set with 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures).
Integrated Population Health Plan Alignment	Rhode Island aims to achieve measurable improvement in the health and productivity of all Rhode Islanders. To achieve this aim, the healthcare delivery, public health, community development, and social service sectors as well as the many academic, public, and private institutions in our state will work together to ensure that all Rhode Islanders are able to achieve their highest health potential, without system/structural barriers. This population health improvement effort requires multi-sector/multi-agency collaborations to help us transition from an uncoordinated, healthcare provider and payer-centric care focused health services environment to an environment where public health, social service, and healthcare delivery systems are well-integrated as well as outcomes-oriented and person-centric. The Integrated Population Health Plan focuses on specific physical and behavioral health conditions or diseases, our aim is to create an approach that centers on wellness, not disease.
Regulatory Levers Development / Use	Rhode Island is committed to using our multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work, identifying the regulatory abilities they have now to move the payment system, support providers and patients, and thus improve population health and address costs. For example, OHIC's Affordability Standards hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting.
Non-SIM Healthcare Transformation	Any other related transformation efforts relating to physical health, including oral health, and behavioral health, including mental health and substance abuse. Other reform efforts, such as criminal justice system reform, may also be included.

Interventions-At-A-Glance

The state is currently in the process of conducting a comprehensive scan of existing work and exploring opportunities for collaboration, scalability and other mutually beneficial enhancements.

The figure on the next page documents the initial mapping of Rhode Island Department of Health (RIDOH) and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). See Operations Plan Page 206 for an initial scan of strategic plans and goals from state departments outside of the realm of public health for ongoing multi-sector/multi-agency alignment.

Table 16: Interventions Categorized and Aligned to SIM

SIM Investment & Focus Area	Existing Initiatives & Activities	Planned Initiatives & Activities	Potential Candidates for Scale-Up/Translation	Overarching Efforts to Align
Community Health Teams • *Obesity* • *Tobacco* • *Chronic Disease* • *Depression*	• Community Health Network • Health Equity Zones • WIC Sites •	• Community Health Worker Certification • Diversify Diabetes Screening Sites • Breastfeeding Café • Doula Services	• Public Health Dental Hygienist • Toxic Stress Experience Screening Tool • OBGYN Care Integration Needs as a PCP • Environmental Collaboration with Healthy Homes, Lead Screening, Food Access	• Obesity Referrals • Family/Home Visiting Screening and Referral for Clinical Prevention Services • Community Paramedicine/ Mobile Integrated Health • Rhode Island Special Needs Emergency Registry • HSRI Resource Specialists • 2-1-1 Resource Specialists
Child Psychiatry Access Program • *Depression* • *Children with Serious Emotional Disturbance* • *Serious Mental Illness* • *Opioid Use Disorder*	• Local Provider operating a service for small number of pediatrician practices • Youth Suicide Prevention Program • First Connections Program • Healthy Transitions Grant	• N/A	• Toxic Stress in Young Children	• PCMH Kids • EMS for Children Programs
PCMH Kids • *Obesity* • *Tobacco* • *Chronic Disease* • *Depression* • *Children with Serious Emotional Disturbance* • *Serious Mental Illness* • *Opioid Use Disorder*	• Childhood Obesity Prevention/TX Referrals • Screening To Succeed • Project LAUNCH • Temas Familiares	• Standardize Protocols for Providers on Childhood Programs	• Text to Be an Ex Referrals	• EMS for Children Programs • Child Psychiatric Access Program • Healthy Families America • Nurse-Family Partnership • Parents as Teachers • Positive Parenting Program • Common Sense Parenting
SBIRT for PCPs • *Tobacco* • *Opioid Use Disorder*	• NOPE Education • Tobacco Cessation Counseling w/ CTC	• Lifespan Quit Line E-Referral	• General E-Referrals • Expansion of Quit Line to Dentists • OBGYN Integration as a PCP	• Drug Overdose Program • SA Peer Staff in Local Emergency Rooms Supporting Victims of Overdoses.

SIM Investment & Focus Area	Existing Initiatives & Activities	Planned Initiatives & Activities	Potential Candidates for Scale-Up/Translation	Overarching Efforts to Align
Integrated Behavioral Health Program for PCPs • *Tobacco* • *Depression* • *Children with Serious Emotional Disturbance* • *Opioid Use Disorder*	• Quit Line • Pilot Integrated Behavioral Health Program for PCPs underway	• Evaluation of Pilot Integrated Behavioral Health Program	• Evaluation of Pilot Program will provide information to advise on options for program expansion • OBGYN Integration as a PCP	• Certified Community Behavioral Health Centers • SBIRT
Care Management Dashboards for CMHCs • *Obesity* • *Tobacco* • *Chronic Disease* • *Depression* • *Children with Serious Emotional Disturbance* • *Serious Mental Illness* • *Opioid Use Disorder*	• Information sharing between inpatient settings and CMHCS occurs through traditional communication methods (e.g. FAX).	• N/A	• N/A	• Certified Community Behavioral Health Centers
Provider Coaching Program for CMHCs • *Obesity* • *Tobacco* • *Chronic Disease* • *Depression* • *Serious Mental Illness* • *Opioid Use Disorder*	• Tobacco Treatment Specialists Certification • Wellness Recovery Action Plans and Motivational Interviewing • First Connections Program Healthy Families America • Nurse-Family Partnership • Parents as Teachers • Positive Parenting Program • Common Sense Parenting	• BHDDH Planning Grant for possible Federal enhancement of CMHCs focuses on closer bridging of medical and behavioral health care.	• South County Hospital's Mental Health First Aid Initiative	• Certified Community Behavioral Health Centers • Pre-Approved Treatment Plans (Tobacco & Medicaid) • Referral to Diabetes Prevention Program
Healthcare Quality Measurement and Reporting Feedback System • *Overarching*	• Integrated Health Home Tobacco Metrics • Immunization Program	• N/A	• SalesForce • Treat Space	• N/A

SIM Investment & Focus Area	Existing Initiatives & Activities	Planned Initiatives & Activities	Potential Candidates for Scale-Up/Translation	Overarching Efforts to Align
Integrated Health and Human Services Data Ecosystem • *Overarching*	• CHDA Data-Sources (BRFSS, YRBS, etc.) • KIDSNET • STARS Program • Prescription Drug Monitoring Program	• CurrentCare Analytics for Adult BMI	• Local Data/Small Area-Estimates Protocols Development • SureScripts	• N/A
Statewide Common Provider Directory • *Overarching*	• Health Professionals Licensing (L2K) • Community Health Network	• My License Office Implementation	• Developmental Screening Directory • Provider Network for Children with Disability •	• Broad Continuum of Care (e.g., Home Health, Paraprofessionals) • Community-Based Providers Referral Directory • Provider Complaints on Public Portal
HealthFacts RI • *Overarching*	• N/A	• Integrated Chronic Disease Surveillance System	• N/A	• N/A
Patient Engagement Tools • *TBD*	• Self-Management Programs • Obesity Program Web-Portal • MH/SA Peer Support Initiatives for Adults • Family Support Programs for Child/Adolescents • Partnership to Reduce Cancer in RI • Skin Cancer Screening • Patient Navigation for Cancer Screening w/ FQHCs	• Diabetes Prevention Recognition Programs • Chronic Disease Social Marketing Plan	• RI Safe Transitions Program • Youth Mentorship and Leadership Supports for At-Risk Individuals	• Customer Service Training • Provider Complaints on Public Portal • NOPE Program • Healthy Families America • Nurse-Family Partnership • Parents as Teachers • Positive Parenting Program • Common Sense Parenting
Advanced Illness Care Initiative • *Chronic Disease* • *Opioid Use Disorder*	• MOLSTs / Advanced Directives • ComfortOne (DNR) • RI Palliative Care and Quality of Life Interdisciplinary Advisory Council • Medical Marijuana Program	• eMOLSTs • Palliative Care Social Media Campaign • Palliative Care Brochure for Cancer Patients • Palliative Care Roundtable	• Exploration of Faith-Based Role or Grief Counselor Role as a CHW	• Partnership to Reduce Cancer in Rhode Island

SIM Investment & Focus Area	Existing Initiatives & Activities	Planned Initiatives & Activities	Potential Candidates for Scale-Up/Translation	Overarching Efforts to Align
Workforce Development • *Overarching*	• Loan Repayment Program • CQI Program • Area Health Education Centers • National Health Service Corps • Certification Program for MH/SA Peer Counselors • Board of Medical Licensure and Discipline Continuing Education Regulatory Levers for Specialties	• Community Health Worker Certification • Statewide Health Inventory (2016 Dental Expansion)	• Dental CE Program • OBGYN Care Integration Needs as a PCP • Public Health Grand Rounds • Micropractice Quality Improvement for Tobacco • Academic Detailing with Providers (Tobacco)	• HEZ Capacity Building • RIDOH Academic Center • Safer Prescribing and Dispensing •
Measure Development / Alignment • *Overarching*	• Tobacco Control Indicators Project • Childhood Obesity Standards	• Community Health Assessment Group (CHAG) Health Equity Indicators Project • Health Equity Zone Measures Development	• Childhood BMI Indicator into Kidsnet • Institute of Medicine Health Equity Measures Report • Statewide Health Inventory (Demographic/ Direct Services Hours Additions)	• HEZ Measures • LGBTTQQ Data and Measurement Workgroup • Small Area Estimates Need
Integrated Population Health Plan Alignment • *Overarching*	• HEZ Assessments • Community Hospital Needs Assessments • Health Improvement Plan	• BHDDH Planning Grant for possible Federal enhancement of CMHCs for closer bridging of medical and behavioral health care.	• N/A	• Health Inventory Results • State Health Pan Requirement • Truven Report
Regulatory Levers Development / Use • *Overarching*	• Local Regulations on Tobacco • Certificate of Need • Managed Care • Utilization Review • Community Benefit Requirements • HIT and Data Regulation/ Requirements • License-Fee Waivers for Education	• Shortage Area Designations • Public Reporting Law • Auto-Enrollment into Prescription Drug Monitoring Program	• Culturally and Linguistically Appropriate Services (CLAS) Standards • Licensing Requirements for Hours or Curriculum	• Smoke-Free Initiatives • Healthy Food Policies • Physical Activity & Schools
Non-SIM Healthcare Transformation • *Overarching*	• Diabetes Prevention Program Covered Benefit for State Employees	• N/A	• N/A	• Health Equity Summit • Social Justice Workgroup • RIDOH LEAN Projects

SIM Investment & Focus Area	Existing Initiatives & Activities	Planned Initiatives & Activities	Potential Candidates for Scale-Up/Translation	Overarching Efforts to Align
	• Oral Health Learning Collaborative Pilot			(Complaints, Licensing)

Existing Interventions

Obesity

Rhode Island's Department of Health (RIDOH) draws inspiration from the state's successful tobacco control efforts in its approach to helping Rhode Islanders maintain a healthy weight. In the same way that tobacco control advocates created policies and regulations to increase the cost of cigarettes, make it more difficult to smoke in public, and reign in aggressive tobacco marketing, state obesity experts aim to "create environments… that better support healthy decisions." The state's 2010-2015 action plan calls for obesity prevention strategies in seven focus areas:[84]

- *Built environment;*
- *Childcare;*
- *Communities;*
- *Healthcare and Insurance;*
- *Schools;*
- *Worksites; and*
- *Infrastructure.*

Major initiatives

- Partnerships with local communities to make improvements in walkability, safety, access to recreation, and access to healthy foods.
- Efforts to increase the percentage of childcare providers that offer meals and snacks that comply with the "Dietary Guidelines for Americans."
- Promotion of community based agencies to implement evidence based nutrition and physical activity programs such as "We Can!" and "5-2-1-0."
- Efforts to include obesity prevention efforts into routine care such as proper screening and identification of obese patients or those at risk of obesity, counseling, referral to healthcare providers such as dieticians or behavioral health providers, and referral to community programs.
- Advocates for access to high quality physical education programs in schools and promoting policies that guarantee that all foods at school and school events contribute to healthy eating patterns.
- Collaborations with employers to implement policy and environmental changes that help their employees increase their physical activity and eat healthy foods.
- Advocates for workplace changes that support breast-feeding mothers.

[84] Dunn, C. (2010). *Nutrition Decisions: Eat Smart, Move More*. Burlington, MA: Jones & Bartlett Learning.

Other Partnerships
RIDOH also partners with a range of contractors and community organizations to encourage healthy eating and more physical activities. The RIDOH Health Equity Zones (described further on page 95 of the Operational Plan) are key partners in these efforts. RIDOH is also working with an outside consultant to implement nutrition guidelines for food and vending options at Providence's Dunkin Donuts Center. The plan improves increasing the availability of healthy options and developing a marketing campaign to encourage spectators to purchase those options.

Tobacco

RIDOH has an extensive tobacco control plan that sets both short-term and long-term initiatives for decreasing tobacco use in the state. The plan consists of four major goals as well as a mass reach communication plan, surveillance and evaluation plan, and an infrastructure, administrative and management plan. The four major goals of the RIDOH tobacco control plan are:

- *Prevent tobacco use initiation among youth and young adults;*
- *Eliminate nonsmokers' exposure to secondhand smoke;*
- *Promote quitting among youth and young adults; and*
- *Address health disparities related to tobacco use.*

Major Initiatives

- A real time surveillance system of community readiness for tobacco related policy change tracking cities and towns with proposals regulating tobacco retail licenses, banning flavored tobacco or cracking down on discounts for tobacco products. The surveillance system also monitors and advocates for policies that create tobacco free campuses for schools/universities/colleges, smoke-smoke free multi-unit housing, and tobacco free public places.
- The STARS (Standardized Tobacco Assessment for Retail Settings) program works with local substance abuse councils and youth groups to measure and collect data about tobacco retailers in more than 13 communities. This program offers useful data about local retailers and also empowers community members to think critically about how tobacco is sold and advertised in their neighborhoods.
- A partnership with "Tobacco Free RI" to push for policy changes and community education activities. By 2017, RIDOH aims to "mobilize and train 30 youth leaders to implement the RI Tobacco Free Youth campaign for point-of-sale policy change" as well as "organize 3 large-scale tobacco awareness events… related to nationally-recognized tobacco control days to mobilize network partners and advocates."
- A well-established Quit Line that provides counseling and support for Rhode Islanders who want to stop smoking. Rhode Islanders might learn about the quit line through direct advertising or they may receive a referral from their doctor.
- "Text to be an Ex" – a pilot program which used a combination of automated messages and trained tobacco counselors to offer smoking cessation counseling though text messages to young people. The six-month pilot program collected valuable data about the success of this method.

Chronic Diseases: Diabetes, Heart Disease, and Stroke

There are several initiatives across the state focused on reducing the burden of chronic conditions among Rhode Islanders. These initiatives utilize a range of disease surveillance, prevention, and management strategies. Examples of some of these chronic disease reduction initiatives include:

- Working with healthcare providers to identify patients at high risk for diabetes and hypertension before the patients actually develop these diseases, as well as identifying undiagnosed cases;
- Promoting healthcare providers' use of the *Community Health Network*[85], through which patients are referred to community-based lifestyle change programs such as:
    - *Diabetes Prevention Program*, which provides education on healthy diet, physical activity, and smoking cessation;
    - *Certified Cardiovascular Disease Outpatient Educators and Certified Diabetes Outpatient Educators,* which are Registered Nurses, Registered Dietitians and pharmacists who teach individuals how to manage their blood pressure and cholesterol, how to properly use medication, and the basics of a healthy diet.
    - *Living Well Rhode Island, Chronic Disease Self-Management*, which is a program led by certified Peer Leaders who teach participants ways to manage symptoms and medications, communicate with family and doctors, handle difficult emotions, relax, eat well, exercise, and set goals to improve health and lifestyles.
- Expanding the availability and affordability of lifestyle change programs across Rhode Island, in both English and Spanish;
- Working with employers to expand worksite wellness programs;
- Providing ongoing training to healthcare providers on best practices for encouraging patient self-management of chronic conditions (e.g. monitoring blood pressure, medication adherence, etc.).
- The development of a surveillance framework to advance data-driven integration efforts across these initiatives.

Children with Social and Emotional Disturbance

Home Visiting Practices

Evidence-based home visiting practices (e.g., Healthy Families America, Nurse-Family Partnership, and Parents as Teachers; First Connections; Positive Parenting Program; Common Sense Parenting) are federally funded programs that predominantly serve the four Core Cities of Providence, Pawtucket, Woonsocket and Central Falls. The Nurse Family Partnership has been found to consistently improve women's prenatal health, reduce children's injuries, reduce children's behavioral problems in early elementary school, and reduce depression, anxiety, and use of substances in early adolescence.[86]

Awarded Grants

Rhode Island is in various stages of implementation of a number of federal grants intended to impact behavioral health morbidities among target populations. Each of the grants is intended

[85] Association of State and Territorial Health Officials. Rhode Island Uses Community Health Network to Increase Access to Chronic Disease Management [available online: http://www.astho.org/Programs/Prevention/Rhode-Island-Community-Health-Network-Case-Study/]

[86] "Improving the Life-Chances and Economic Self-Sufficiency of Families in Poverty with the Nurse-Family Partnership," David Olds, Professor of Pediatrics, University of Colorado School of Medicine.

to develop cross-agency strategies in order to better address the needs of target populations.

"Healthy Transitions RI" is targeted to serve youth and young adults ages 16-25 with Serious Emotional Disturbance (SED), Severe Mental Illness (SMI) and/or Co-Occurring Disorders (COD) in Woonsocket and Warwick. The purpose of the grant is to bridge the division of responsibility for these young people between state agencies, service providers, families and others by developing a shared "locus of responsibility" for their successful care.

Each community has built a local advisory structure to guide the local development of the project, make the communities aware of the needs of their youth/young adults, collaborate to help identify, engage and screen at risk children, and provide specialized intensive services to those who are experiencing serious mental illness of co-occurring disorders. These services will involve a number of Evidence Based Practices delivered within the Coordinated Specialty Care (CSC) model.

The Rhode Island Youth Treatment Planning project is targeted to serve youth ages 12-25 with substance use disorders and/or co-occurring substance use disorders and mental health conditions by creating a unified, recovery focused service approach. The strategies are intended to support the State departments in leveraging collective resources, ensuring that individuals served and their families have meaningful input into the development of policies and practice and facilitating exploration of a necessary and appropriate statutory response.

Serious Mental Illness

Integrated Health Homes

Implemented in January 2016, Rhode Island Integrated Health Homes (IHH) for persons with serious and persistent mental illness are responsible for coordinating and ensuring the delivery of person-centered care; providing timely post discharge follow-up, and improving client health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

As part of Rhode Island's Reinventing Medicaid initiative, IHHs provide a tiered service approach based on an individual's condition and level of need. IHHs place emphasis on the monitoring of chronic conditions, preventive and education services focused on self-care, and wellness and recovery. Clients' medical and behavioral benefits are administered by the same managed care organizations, which is intended to facilitate clinical integration across the continuum of care in order to achieve substantial clinical improvement.

Certified Community Behavioral Health Clinics

In 2015, Rhode Island applied for, and was one of 24 states awarded, a Certified Community Behavioral Health Center Planning Grant. The Planning Grant provided Rhode Island with funding to plan for and begin transforming Community Mental Health Centers (CMHCs) to become "centers of excellence" of behavioral health treatment. Certification is intended to expand and elevate the ability of the CMHCs to better respond to the needs of the communities they serve. Desired outcomes include:

- Fully accessible services, including services outside the walls of the Centers;
- Individualized, person-centered care across the lifespan;

- The provision of evidence-based care including integrated primary and substance use disorder care, integrated primary care practices and Medication Assisted Treatment for Opiate Disorders;
- Enhanced quality of care;
- Enhanced data collection and reporting, used to drive quality improvement; and
- Establishment of a value-based payment structure that rewards the outcome of services rather than the volume of services.

Aligned with a population health approach, certified CCBHCs will be responsible for the behavioral health needs of all residents within their catchment areas and not just the individuals who come to their doors for service. Responsibilities will include working with communities to promote behavioral health and well-being, prevention, early identification of disorders to stem further progression, and stratification of the population with age-appropriate, targeted interventions across the lifespan.

Opiate Use Disorders

Emergency Department Recovery Program
AnchorED connects individuals who have presented at Rhode Island emergency rooms with an opioid overdose with recovery services delivered by certified peer recovery coaches. Prior to being released, a peer recovery coach from Anchor Recovery Community Center meets with the individual to introduce them to recovery supports and resources that will help keep them on the road to recovery. Recovery coaches play an important role in helping individuals avoid another overdose and encouraging them to stay engaged in treatment. Outreach includes:

- Linking individuals to treatment and recovery resources;
- Providing education on overdose, prevention and obtaining Naloxone, a drug that reverses the effects of an opioid overdose when administered properly;
- Providing additional resources to individuals and family members; and
- Contacting the individual after they are released from the ED with a follow-up phone call.

Recovery coaches are on call 24/7 at Kent, Memorial, Rhode Island, Miriam, Newport, Hasbro, Landmark, and Westerly hospitals. Recovery Coaches' consultation results in 83% of participants receiving confirmed linkage to substance use disorder treatment within 48 hours.

Prescription Drug Monitoring Program (PDMP)

The RIDOH Prescription Monitoring Program aims to detect overprescribing, and diversion or fraud related to prescription of controlled substances. The program does this by tracking the use of controlled substances, ensuring that controlled substances are used for legitimate medical purposes, maintaining effective operational controls against drug diversion and reporting suspected drug diversion to law enforcement.

In 2014, the Rhode Island General Assembly passed legislation requiring all prescribers with an active Controlled Substance Registration (CSR) to register for the Prescription Drug Monitoring Program (PDMP). Regulations developed by the RIDOH in 2015 requires all prescribers to check the PDMP before prescribing an opioid to a patient and/or when a patient is on opioids for more than 6 months over the course of a 12 month period. RIDOH also strongly encourages providers to review the PDMP before prescribing any controlled substance.

The State's Rules and Regulations for Pain Management also include:

- Requirements for periodic review of the patient at least every 12 months
- Requirements for patient education that includes a focus on discouraging co-administration with benzodiazepines and encouraging urine drug tests
- Transition of care for patients dependent on opioids
- Consideration of multidisciplinary approaches to the treatment of chronic pain

In addition to the enhanced PDMP, the Rhode Island Department of Health is taking steps to reduce the supply of opiates through:

- Tightened prior authorization practices and limits on the supply of opioid medications obtained from Emergency Department physicians;
- Promoting safer opiate prescribing practices; and
- Promoting a public education campaign.

EOHHS, RIDOH, BHDDH, and a network of community partners will develop and implement an aggressive public education and communication plan to end the stigma of addictions and promote prevention, treatment, recovery and rescue. The campaign includes launching the website – www.PreventOverdose.RI.gov – which will include a public dashboard based on Rhode Island's Strategic Plan on Addictions and Overdose.

Rhode Island Opiate Task Force
The Rhode Island Opiate Task Force's Strategic Plan recommends three overarching strategies in order to impact the Opiate overdose epidemic in Rhode Island:

- Treatment Strategy: The core of this initiative recommends the development of a system of medication-assisted treatment at every location where opioid users are found, primarily: the medical system (Emergency Departments, hospitals, clinics, etc.); the criminal justice system; drug treatment programs; and in the community.
- Overdose Rescue Strategy This initiative seeks to ensure a sustainable source of naloxone for community and first responder distribution, and a high coverage of naloxone among populations at risk of overdose.
- Prevention Strategy The main focus of this strategy is to use prescribers, the Prescription Drug Monitoring Program (PDMP), and system-level efforts to reduce co-prescription of benzodiazepines with opioids (for pain or opioid use disorder).

Examples of Planned SIM Investments and Aligned Activities

SIM Component: Community Health Teams

Community health teams (CHTs) currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs improve population health by addressing these social, behavioral, and environmental needs. SIM-funded CHTs will also support providers in transitioning to value based systems of care and help transform primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures.

Related Health Focus Areas
Tobacco use, obesity, heart disease and stroke

Alignment with the Community Health Network
In their work to connect Rhode Islanders with appropriate clinical and community resources, Community Health Teams have the potential to move the needle on a number of our health focus areas, including tobacco use, obesity, heart disease, and stroke. A potential partner in these efforts is the Rhode Island Department of Health's (RIDOH) Community Health Network.

The Community Health Network consists of a coordinated system to provide evidence-based and best practice education to activate patients and improve patient skills necessary to self-manage their chronic condition(s). The Community Health Network is a partnership between multiple evidence-based programs based at RIDOH and within organizations outside of RIDOH that work on chronic disease management. The Community Health Network is building a skilled workforce of expertly trained staff consisting of both professional and community health workers who provide disease/self-management programs, chronic disease management programs, and patient navigation.

Components of the system include a centralized referral system with secure fax and email to RIDOH, follow up with the patient to assist with access to the CHN resources, and communication back to the practice concerning the patient experience. Evidence Based Programs include:

- *Certified Diabetes Outpatient Educators (CDOE)*
- *Diabetes self-management*
- *YMCA's Diabetes Prevention Program*
- *National Diabetes Prevention Program*
- *Cardiovascular Disease Outpatient Educators (CVDOE)*
- *Chronic disease self-management*
- *Enhancefitness*
- *Quitworks*
- *Chronic Pain Self -Management)*
- *Peer Resource Specialists / Peer Navigators*
- *A Matter of Balance: Managing Concerns About Falls*
- *Certified Asthma Educators (AE-C)*
-

Alignment with Professionalizing Community Health Workers
Community Health Workers are frontline public health workers who serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery. Typically, community health workers are non-licensed, gain expertise from life experience and some community/health education. The lack of health professional licensing makes it difficult for Community Health Workers to receive reimbursement for the valuable role they play in improving the health of their community and working with a health team.

RIDOH is well-underway in developing a community health worker (CHW) certification process to strengthen and grow this important workforce. In addition to certification, there are several CHW infrastructure building projects in the planning stage that involve a partnership with Rhode Island College to offer the CHWs core competency training, support CHW employers, and provide additional opportunities for specialization in focus areas such as behavioral health.

SIM Component: Child Psychiatry Access Program

The Pediatric Psychiatry Referral Consultation project will establish a children's mental health consultation team to support pediatricians and other primary care doctors serving children and adolescents with mental health conditions. The Access Program is designed to assist pediatricians and other physicians in treating children with behavioral and mental health needs in a way that is preventive and responsive to a patient's immediate circumstances.

Related Health Focus Area

Children with serious emotional disturbance

Alignment with Cedar Family Services

The Child Psychiatry Access Program will build on already successful efforts to link children and their families with timely and appropriate behavioral health services, including the Cedar Family Centers. Cedar Family Centers provide navigation support and care coordination to families to assist them in accessing services across the number of agencies responsible for providing treatment for children with special healthcare needs. Children eligible for Cedar Family Centers include Medicaid recipients who meet the following criteria:

- *Has a severe mental illness, or severe emotional disturbance*
- *Has two or more chronic conditions as listed below:*
    - *Mental Health Condition*
    - *Asthma*
    - *Diabetes*
    - *Developmental Disabilities*
    - *Down Syndrome*
    - *Mental Retardation*
    - *Seizure Disorders*
- *Has one chronic condition listed above and is at risk of developing a second*

Cedar Family Centers have been very effective in providing navigation support and care coordination, but have been limited in their ability to impact the actual care children and their families receive. By joining forces with the newly funded Child Psychiatry Access Program, Cedar Family Centers can enhance their ability to provide:

- *Earlier identification of BH disorders and*
- *Prompt initiation of appropriate treatment, including medications as necessary.*

When children are diagnosed with behavioral health conditions which exceed the capacities of a typical patient-centered medical home, even with the added consultation, it is critical that there be prompt referral to a specialized behavioral health provider. CMHC practice transformation will help to insure that age-appropriate evidence-based practices to treat children and adolescents and their families are available.

SIM Component: Integrated Behavioral Health Patient Centered Medical Home

The Integrated Behavioral Health Patient Centered Medical Home Pilot is an overarching program designed to address multiple areas of behavioral health, including depression. The pilot is a practice transformation program that aims to:

1. *Increase the identification of patients with behavioral health and substance use disorder (SUD) through universal screening for depression, anxiety and SUD.*

2. *Increase access to brief intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions.*
3. *Improve care coordination for patients with severe mental illness and SUD.*
4. *Provide care coordination and intervention for patients with high emergency department (ED) utilization.*
5. *Test the proposed financial model for long term sustainability with particular attention to ED and inpatient (IP) utilization/total cost of care as sustainability measures.*

The Care Transformation Collaborative of Rhode Island (CTC) is coordinating this program and seeks to establish a pilot (10 practices in Years 1-2 and 10 practices in Years 2-3) with a phased start up and performance year implementation schedule.

Both phases will address the following goals:

- Increase patient access to behavioral health services within primary care settings,
- Increase patient identification and treatment of mild to moderate behavioral conditions,
- Reduce patients' risk and cost, and
- Increase staff competence with providing integrated behavioral health services.

SIM Component: Patient Engagement Tools

In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest funds to provide patients access to tools that increase their involvement in their own care, including creating the infrastructure to allow patients to more easily share their advanced care directives and healthcare proxies with their providers; developing patient engagement tools such as health risk assessments; and implementing tools that measure consumer satisfaction as well as behavior change readiness.

Related Health Focus Area

Overarching

Alignment with Diabetes Prevention Program

The Rhode Island Department of Health's efforts to decrease the number of people with pre-diabetes or who are at risk for diabetes encourages Rhode Islanders to enroll in the free Diabetes Prevention Program (DPP). This national program, developed by the CDC, is an evidence based lifestyle change program for preventing or delaying the onset of type 2 diabetes. It can help people cut their risk of developing type 2 diabetes in half through modest weight loss, regular physical activity and improving food choices.

The Department of Health plans to boost participation in the Diabetes Prevention Program by launching a statewide marketing campaign educating Rhode Islanders about the program and pre-diabetes in general. This effort could benefit from aligning with other patient engagement tools and dissemination strategies funded by the SIM investment.

Stakeholders and Governance

SIM's Integrated Population Health Plan is tightly woven into our Operational Plan, and thus the answers to the questions in Section 10, on the Governance and Maintenance of the Plan, will primarily refer to language found throughout the larger document.

Policy and Legislative Framework

Rhode Island's ability to carry out an effective SIM program is based on our significant legislature and regulatory support for healthcare system transformation. Throughout the Operational Plan, we describe the regulatory authority of the Office of the Health Insurance Commissioner (OHIC) and our Medicaid office. They are working together to implement aligned value-based payment strategies, supported by OHIC's Affordability Standards and the recent changes to the Medicaid program made by Governor Raimondo's Reinventing Medicaid Workgroup.

The other SIM-participating state departments also have legislatively or administratively mandated bodies or rules that support SIM's work, including the Rhode Island Department of Health's (RIDOH's) Commission for Health Advocacy and Equity, which aims to improve population health through a focus on the social and environmental determinant of health, and the Department of Behavioral Health, Developmental Disabilities and Hospitals, which helps to regulate the way Rhode Island addresses opioid addiction.

More detailed descriptions of these frameworks are found in the following sections of the Operational Plan: Healthcare Delivery System and Payment Transformation Plans Section (Page 168) and the Leveraging Regulatory Authority (Page 184).

Sustainability Model

Clearly, the sustainability of the SIM interventions is a critical priority for our entire project. The SIM Interagency Team and other leadership from the Steering Committee have considered this carefully and will continue to do so throughout the three years of the implementation of the Test Grant. Our most current thinking about sustainability plans for each of the SIM interventions is found in our SIM Sustainability Strategies chart. In the chart, we detail sustainability proposals for each intervention plus our payment model, and we include a definition of success for the SIM interventions.

Leveraging Interoperable Health Technology

Rhode Island has been a national leader in HIT for years, with our elected and community health leadership believing that HIT is a cornerstone of our strategy to increase Rhode Island's healthcare quality and implement our planned system transformation. Starting on Page 221 in the Operational Plan, we share our HIT plans in great detail, including the governance and implementation of an interoperable and aligned system.

Developing New Population Data Sets

We are also planning to collect new data by required all of the entities who we choose as vendors to carry out significant data collection strategies. We will make these requirements very clear throughout our procurement processes and work with our vendors to gain as much new data as possible, which we can document through our HIT resources.

Using HIT for Care Coordination

Again, our HIT section in the Operational Plan details our strong commitment to use technology to improve care coordination across all entities. In particular, we are investing in a modernized State Data Ecosystem that will link across multiple state agencies. In our description of the Ecosystem, we provide examples of the questions that could be answered as a result of the updated technology:

Which Medicaid high utilizers, when combined with social support, economic, demographic, and other social determinants of health information, are most likely to benefit from case management interventions? Who are most likely to be homeless and benefit from home stabilization services, thus lowering costs? If the family received WIC, SNAP, or TANF, could an ACO build into the family's care plan reminders for renewals and support for interacting with DHS if benefits are interrupted? Can care plans emphasize self-care for known chronic diseases that will flare without attention (theoretically exacerbated by stress, focusing on the care of others)? Can care managers inform families of low-acuity alternatives for emergency rooms, ambulance transport and urgent care centers? For high risk cases, can care managers train families on how to manage, identify signs of true emergency at home?

Being able to link the data to serve clients at this level of integration will be groundbreaking for our state departments and for the Rhode Islanders we serve.

Quality Measure Alignment

One of the first activities Rhode Island took on as we began our SIM work was a Measure Alignment project, to lessen the number of measures providers had to report, and to align them for population health reporting. Our Steering Committee Chairman, Lou Giancola, was so committed to this activity to that he raised the funds to hire Michael Bailit, even before we had federal SIM dollars to allocate. With support from OHIC, Mr. Bailit facilitated our Measure Alignment Workgroup that successfully created a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). Detailed information about our Quality Measure Alignment process is on Page 189 of the Operational Plan.

Quality Measure Monitoring

One of SIM's promising HIT investments is our Healthcare Quality Measurement Reporting and Feedback System. Our goal is to use this system to help providers import quality measures once and analyze many times. We are committed to improving the state's data capacity, so that providers have new skills to use this data to improve their practices' quality – and we are excited about how we can use this system to help Rhode Island providers to prepare for QPP. (We hope they will be pleased that it will be ready for them even before they know how much they need it.) Detailed information about the Feedback System is on Page 234 of the Operational Plan.

Community Capacity Building

As we describe throughout our Operational Plan, we are strongly committed to the concept of integration and alignment of our new SIM investments with current healthcare spending both in government and in the for-profit and nonprofit community sector. Some of this alignment will take place by leveraging dollars, other pieces of it will come through heightened levels of community, and we will find new opportunities to help build community capacity. Right now, one of the most important state investments in community capacity is through RIDOH's Health

Equity Zones, described on Pages 201. We will add to that capacity with our new investments in Provider Coaching for Community Mental Health Centers (Page 51), the Child Psychiatry Access Program (Page 47), and potentially some of the patient engagement activities we fund, including End-of-Life care (Page 52).

Stakeholder Engagement and Information Sharing

Community Engagement

Stakeholders have been actively engaged in the development of the SIM Integrated Population Health Plan and continue to lend their voice to the project. The Integrated Population Health Workgroup was convened to provide subject matter expertise and general community input into the population health needs of Rhode Islanders and the existing, and potentially new, activities to improve population health outcomes. The group met monthly February through April and will continue to meet as we move into the maintenance phase of the plan. The Stakeholder Engagement section of the Operational Plan starting on Page 89 further describes the role of Steering Committee commissioned workgroups within the SIM governance structure.

A SIM Outreach and Engagement Effort will be launched in June 2016 to strengthen the ongoing development of the Integrated Population Health Plan and to enhance SIM's ability to achieve stated Population Health outcomes. This effort will complement our highly successful state-level stakeholder engagement with targeted community-based outreach to healthcare providers working directly with patients and target populations in order to further expand support for and investment in the SIM outcomes. Up to three pilot outreach and engagement opportunities will be scheduled June through August 2016. Lessons learned from the pilots will inform strategy and materials moving forward.

To guard against duplicative meetings, we will partner with existing community organizations to engage "front line" constituencies through existing structures, meetings and conferences. Potential partners include Health Equity Zones throughout the state, Community Health teams, Provider Advisory Group, Healthy Body/Healthy Minds, and Brown Alpert Medical School, among many others. These gatherings will engage the healthcare workforce in the planning and implementation of the Integrated Population Health Plan by gathering critical input, identifying new and creative strategies to maximize linkages among existing initiatives, and better understanding how to overcome persistent barriers to improved Population Health outcomes. Accessible information about SIM for a wider audience will be created including exploring a variety of visual mediums (video, web, other social media platforms) to complement written materials.

Information Sharing with Providers

One of the reasons that we are so committed to our Integration and Alignment Project is because of the opportunities we believe exist throughout our system for providers to share more information about the significant number of existing and upcoming community-based services that could serve more Rhode Islanders. For example, our Community Health Teams are a crucial link between clinical offices and the communities they serve and are one of our most important SIM interventions. They are described in detail starting on Page 43. Our most important goal for the Teams is to ensure that we collect the data we need to prove their Return on Investment (ROI), so that we can leverage long-term funding. In addition, we are excited that Rhode Island has just received a significant SBIRT grant from SAMHSA. We plan for SIM to

help support the SBIRT training for providers, who will then offer brief interventions or referrals for more care (described on Page 50). One of the most important parts of our SBIRT project, however, will be to strengthen the relationships between the referring providers and the agencies they will refer to – because we know that those relationships are not currently strong enough to ensure that everyone who needs services is getting them in a timely fashion.

Evaluation and Monitoring

Our SIM staff and leadership are all committed to an evaluation process that is formative and summative – in other words, will allow us to review the progress we are making toward our goals as we create the interventions, help us make changes to more effectively achieve our goals, and allow us to share what is working and what needs to change. We are in the process of procuring our state evaluation team. Our Steering Committee leadership has also approved a learning collaborative process on the alternative payment model process that will help us explore how APMs work for which type of providers–and how to expand their reach. We describe our evaluation process in detail beginning on Page 247.

Healthcare Delivery System and Payment Transformation Plan

Traditional state functions for advancing policy consist of the state as convener, purchaser, regulator, infrastructure funder, and evaluator.[87] Rhode Island's State Innovation Model (SIM) Test Grant is structured such that its footprint marks each of these domains of state action and, at a high level, SIM acts as a collaborative space, or hub, for interagency policy alignment and coordination as well as a public/private partnership with its Steering Committee and other stakeholders. Rhode Island is committed to transform the local healthcare system through the coordinated use of regulatory and purchasing levers, direct investment in workforce and health information technology infrastructure, and public-private collaboration.

Baseline and Vision

Rhode Island's current healthcare system is not built to achieve the socially desirable results of improved physical and behavioral health for the state's residents, nor is the system financially sustainable. Rhode Island's current healthcare system relies on fee-for-service reimbursement, which rewards volume generation and promotes fragmentation of care, resulting in duplication of lab and imaging services, unnecessary hospitalizations and emergency department visits, and unmet patient needs. There remain important gaps in health information technology, data infrastructure, and support for Rhode Island's healthcare workforce as well.

Through the assistance of a State Innovation Model Design grant in 2013, and the development of the Rhode Island SIM Test Grant proposal in 2014, Rhode Island's healthcare stakeholders, public and private, have asked what resources, policy initiatives, and market rules are necessary to transform the local healthcare system to meet the goals of the Triple Aim.

As noted above, Rhode Island's SIM Test Grant is built on the premise that transitioning to healthcare payment models that reward value, as opposed to volume, and incentivize providers to work together, is a necessary step toward building a sustainable healthcare delivery system that:

- Promotes high quality, patient-centered care that is organized around the needs and goals of each patient;
- Drives the efficient use of resources by providing coordinated and appropriate care in the right setting; and
- Supports a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of the social determinants of health.

Changing financial incentives is necessary, but not sufficient, for building a healthcare system that meets our vision. Rhode Island's SIM Test Grant coordinates state agency purchasing and regulatory initiatives along with private sector efforts to promote value-based payment and integrated delivery system structures, such as accountable care organizations (ACOs), which

[87] Recommendations Regarding State Action to Promote and Regulate Accountable Care Organizations (ACOs). A Legislative Report Required by Section 6(n) of the Rhode Island Health Care Reform Act of 2013 RIGL 42-14.5-3.

support population health management. At the same time, the Rhode Island's SIM deploys direct investments in system transformation, encompassing support for Rhode Island's healthcare workforce and health information technology infrastructure.
Rhode Island views payment reform as a necessary ingredient toward building integrated delivery models, such as accountable care organizations (ACOs), which can manage population health, provide high quality services, and reduce cost. We envision ACOs as relying on a foundation of patient-centered medical homes (PCMHs) which have links to the community through community health teams (CHTs). In order for providers to form partnerships and work in an integrated way, the prevailing payment models which incent and reward integration must achieve critical mass across all payers. While payment reform is already underway in Rhode Island, below we articulate an innovative regulatory approach that will spur greater uptake of value-based payment in Rhode Island, ultimately shaping the pace and content of system transformation. Our hypothesis is that payment reform will drive the continuing development of existing ACOs, incent continuing practice transformation in primary care, and change the economic dynamics of our healthcare system. To facilitate this transformation, we will use SIM dollars to make investments in infrastructure and untested, but promising, models of care delivery.

Robust primary care infrastructure represents necessary groundwork for system transformation and successful implementation of payment models that reorient provider financial incentives toward value. At the outset of the SIM project, Rhode Island had a strong base of transformed primary care practices to build on. In 2015 about 55 percent of primary care network clinicians (including Nurse Practitioners and Physician Assistants) were based in practices that had achieved NCQA Level 3 accreditation or were on the path toward achieving NCQA Level 3 accreditation. Two long-standing initiatives have prepared this groundwork for system transformation and payment reform. The first is Rhode Island's multi-payer patient-centered medical home (PCMH) initiative, Care Transformation Collaborative of Rhode Island (CTC-RI), which includes 72 practice sites. The second was a concurrent PMCH initiative through Blue Cross Blue Shield of Rhode Island.

The Rhode Island Approach to Transformation

The Rhode Island approach to healthcare system transformation is statewide and comprises the following elements:

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value[88] with a regulatory strategy to achieve these goals.
2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.

[88] Rhode Island will track payments linked to value by crediting the total dollar value of provider contracts with performance-based incentives (such as P4P) toward the numerator of the ratio.

4. Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved physical and behavioral health for the state's residents.
5. A Multi-Sector/Multi-Agency Approach. One of the main strategies of Rhode Island's SIM project is to reach a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This will allow us to build on current achievements, expand the reach of these initiatives, avoid duplication of funding, and, we expect, save money.

The transformation activities executed and planned within each of these four elements are discussed below.

1: Value-Based Payment Using Purchasing and Regulation

Coordinated and aligned approaches to expanding multi-payer value-based payment models (Medicaid and commercial insurance) through state purchasing and regulatory levers.

Current initiatives through the Centers for Medicare and Medicaid Services (CMS) and the Health Care Payment Learning and Action Network (LAN) emphasize the importance of reaching a "**critical mass**" of payers engaged in payment reform to ensure that the attendant financial incentives of value-based payments are strong enough to support system transformation.[89] Rhode Island has derived great benefit from the Alternative Payment Model Framework developed by the LAN and published in January 2016. In what follows, the terms *value-based payment* (VBP) and *alternative payment models* (APM) are consistent with APM Framework categories 2 – 4 (VBP broadly) and 3 – 4 (APM), respectively.

At the outset of the SIM project, uptake of VBP and APMs was uneven across the local Rhode Island healthcare market. Commercial insurers and their provider networks had the longest experience contracting under VBP and APMs. In 2014, 24% of commercial insured medical payments were made under an APM, largely comprised of fee for service payments made under population-based APMs with shared savings. These contracts were generally no more than two years old. Moreover, all commercial insurers with a minimum of 10,000 covered lives were required by the Office of the Health Insurance Commissioner to have quality improvement programs with hospitals, and to tie at least 50% of annual hospital price increases to quality, which are subject to an overall inflation cap. Commercial insurers also had pay for performance contracts in place with most of their primary care networks. By July 15th 2016, Rhode Island will provide updated data on the penetration of APMs in the commercial market and baseline data on uptake of VPB models, the latter of which likely touch 50% of medical spending. VBP models and APMs were in an early stage of development in the Medicaid market and baseline data will be available in the summer of 2016. Quality measures used for value-based contracting were not aligned across major payers, thus creating demands among provider organizations to align quality measures as a means to facilitate implementation of innovative payment models and ease administrative burden.

Year 1 (Pre-Implementation)

To accelerate payment reform, and coordinate action across all payers, the Office of the Health Insurance Commissioner (OHIC) and Medicaid stewarded two closely aligned processes to advance VBP and APMs in their respective market jurisdictions. OHIC and Medicaid have explicitly aligned payment reform targets with those announced in January 2015 by Secretary of

[89] Rajkumar R, Conway P, Tavenner M. CMS – Engaging Multiple Payers in Payment Reform. JAMA. 2014; 311(19): 1967-1968.

Health and Human Services Sylvia Mathews Burwell,[90] later adopted by the LAN, and those articulated in the SIM Round Two Test Grant Funding Opportunity Announcement. As a core component of its model test, Rhode Island intends to drive achievement of the CMS/LAN goals at the state level using significant regulatory levers at Medicaid and OHIC.

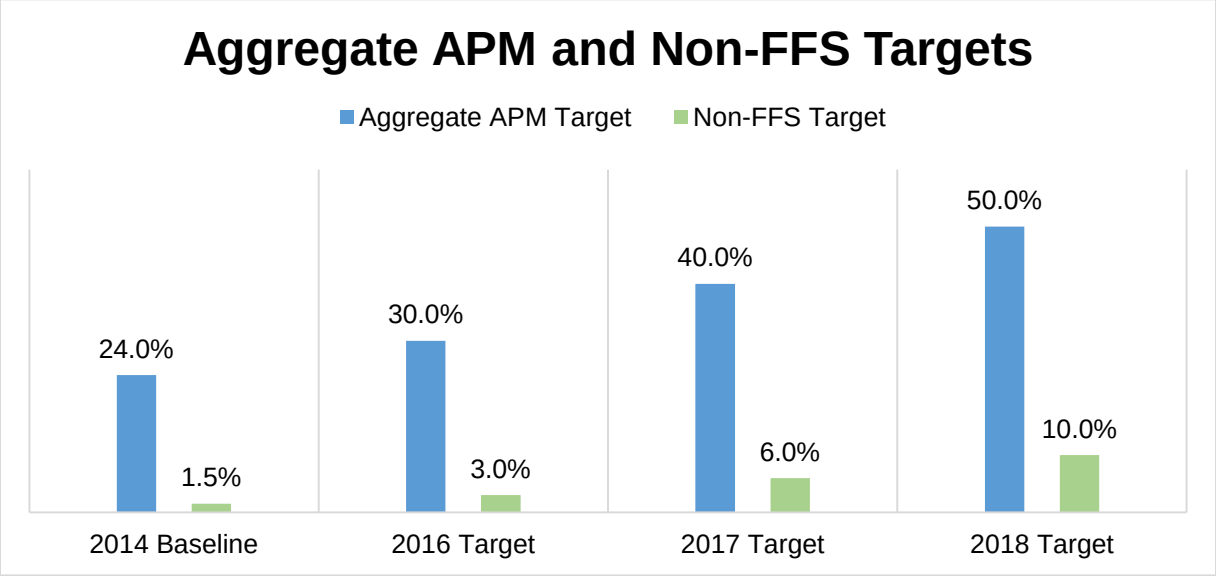
In Year 1 the SIM Project Director coordinated meetings between OHIC and Medicaid to ensure alignment of these initiatives. The SIM project has initiated an unprecedented level of interagency coordination and alignment in Rhode Island. The use of state regulatory and purchasing levers to achieve the state's payment reform targets are discussed in turn.

Commercial Insurance Regulation

Payment Reform

In February 2015, the beginning of the Rhode Island grant period, OHIC promulgated regulations that required commercial insurers to "significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services."[91] To carry out this provision OHIC convened an Alternative Payment Methodology Advisory Committee, which held two rounds of meetings, in the spring and fall. The key objectives of the meetings were to define APMs, collect data from health plans to measure the baseline rate of APM uptake, and to develop **binding annual regulatory targets** for commercial insurer use of APMs through 2018. The outcome of the OHIC process was the promulgation of regulatory targets for commercial insurers based on percent of insured medical spending that is made under an APM according to the following schedule:

Figure 46: Rhode Island Commercial Payment Reform Targets



[90] U.S. Department of Health and Human Services. (2015). *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value* [Press Release]. Retrieved from http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

[91] OHIC Regulation 2 Section 10(d)(2)

In consultation with stakeholders, OHIC developed the following specific definition of APMs:

"Alternative Payment Methodology means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- *Improving quality of care;*
- *Improving population health;*
- *Reducing cost of care growth;*
- *Improving patient experience and engagement, and*
- *Improving access to care.*

To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a "budget" that may be prospectively paid or retrospectively reconciled. Providers are rewarded for managing costs below the budget (should quality performance be acceptable), by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years 2016 and 2017.

Health plans shall also receive credit for pay-for-performance payments and supplemental payments to specialists intended to provide incentives to improve communications and coordination among PCPs and specialists.

Approved Alternative Payment Methodologies include:

- *Total cost of care budget models;*
- *Limited scope of service budget models;*
- *Episode-based (bundled) payments;*
- *Infrastructure payments and pay-for-performance payments for 2016-2017, and*
- *Other non-fee-for-service payments that meet the definition above as approved by OHIC."*

The targets promulgated by OHIC, and presented in Figure 3 above, are defined as follows:

(1) "Alternative Payment Methodology Target" means the aggregate use of APMs as a percentage of an insurer's annual commercial insured medical spend. The APM Target shall include:

- *All fee-for-service payments under a population-based total cost of care contract with shared savings or shared risk;*
- *Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments;*
- *Supplemental payments for infrastructure development and/or Care Manager services to patient-centered medical homes, specialist practices, and accountable care organizations, and all pay-for-performance payments for 2017, and*
- *Shared savings distributions.*

(2) "Non-Fee-for-Service (FFS) Target" means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer's annual

commercial insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:

- *Episode-based (bundled) payments, either prospectively paid or retrospectively reconciled, with a risk component;*
- *Limited scope-of-service capitation payments and global capitation payments;*
- *Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation);*
- *Shared savings distributions, and*
- *All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes, specialist practices, and accountable care organizations, for 2017.*

While OHIC's jurisdiction spans fully insured plans only, and regulatory targets for use of APMs are established on the basis of fully insured medical spend, it is reasonable to expect that the use of APMs measured on the basis of self-insured medical spend will track closely with fully insured due to insurers' use of single contracts with providers that do not differentiate members by funding status. Baseline data on APM use in the commercial market in 2014 found that the percentage of medical payments made under an APM was roughly the same when evaluated over self-insured spend and fully insured spend. Therefore, we expect the effects of commercial insurance regulation with respect to health care payment models to have a spill-over effect on self-insured medical spend.

Care Transformation

As noted earlier, robust primary care infrastructure represents necessary groundwork for system transformation and successful implementation of payment models that reorient provider financial incentives toward value. Thus, care transformation is also a crucial piece driving the healthcare system toward a critical mass of value-based payment. Commercial insurers are required by OHIC to expand the percentage of their primary care networks that are functioning as patient-centered medical homes. OHIC aims to have 80% of insurer network primary care clinicians practicing in a PCMH by 2019. Working with its Care Transformation Advisory Committee, OHIC has adopted a more rigorous definition of PCMH and a payment model geared toward sustaining transformed practices.

Beginning in 2017, commercial insurers will have to meet targets for percentage of primary care clinicians practicing in a PCMH based on the following definition of PCMH:

- *Practice is participating in or has completed a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, RIQI'S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.*

- *Practice has implemented the following specific cost-management strategies:*
    - *Develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;*

    - *Practice uses data to implement care management, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;*

- *Implements strategies to improve access to and coordination with behavioral health services;*
- *Expands access to services both during and after office hours;*
- *Develops service referral protocols informed by cost and quality data provided by payers; and*
- *Develops/maintains and avoidable ED use reduction strategy.*

- *Practice has demonstrated meaningful performance improvement on a set of clinical quality measures that are derived from the SIM aligned measure set. The measures for PCMHs are given as follows:*
  - The measures for internal medicine and family practices are:
    - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (<8.0%)
    - Controlling High Blood Pressure
    - Tobacco Use: Screening and Cessation Intervention
    - Adult Body Mass Index Assessment
    - Screening for Clinical Depression and Follow-Up Plan
  - The measures for pediatric practices are:
    - Body Mass Index Assessment for Children/Adolescents
    - Counseling for Nutrition and Physical Activity for Children/Adolescents
    - Counseling for Physical Activity for Children/Adolescents
    - Developmental Screening

Performance improvement requirements on the PCMH measures vary by year, and are given as follows:

a. For 2017 recognition:
   i. Internal medicine and family practices: Improve by 3 percentage points on 2 of 3 of the following measures: diabetes HbA1c control, blood pressure control and tobacco use assessment and counseling measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).
   ii. Pediatric practices: Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).
b. For 2018 recognition:
   i. Internal medicine and family practices: Improve by 3 percentage points on 3 of the 5 HbA1c, blood pressure control and tobacco use assessment

and counseling measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).

ii. Pediatric practices: Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).

In 2017, practices that meet the three components of the OHIC PCMH definition will be counted toward achievement of the insurers' PCMH targets. Once a practice has completed a formal transformation imitative and achieved NCQA Level 3 accreditation, and demonstrates annual implementation of cost containment strategies and performance improvement, the practice will be entitled to an ongoing care management payment and an opportunity to earn a performance bonus. The levels of payment will be negotiated between the practice and the health plans, but the Commissioner has articulated to the health plans that the payment must be meaningful.

Enforcement

To implement and enforce the commercial payment reform targets, OHIC leverages its statutory authority and prior approval rate review process. Two of OHIC's statutory purposes grant the Office a clear directive to improve the healthcare system as a whole:

- Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- View the health care system as a comprehensive entity and encourage and direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. (R.I.G.L 42-14.5-2).

Furthermore, the Health Insurance Commissioner possesses authority to consider whether an insurer has implemented effective delivery system and payment reform strategies in the context of the annual rate approval process. Operationally, OHIC's regulatory levers facilitate collective action across commercial payers to invest in delivery system transformation and implement payment reforms as a means to improve the system as a whole and to make health insurance more affordable.

State Medicaid Reforms

Rhode Island's Medicaid program contracts with two Managed Care Organizations (MCOs) for most beneficiaries and services. In 2015, Medicaid, as regulator and purchaser, embarked on a lengthy public process to transform the state's Medicaid program and drive transformation of the healthcare system as a whole. This process resulted in several key reforms, including a Medicaid Accountable Entities (AE) Coordinated Care Pilot Program. Under the Coordinated Care Pilot Program, pilot AEs enter into contractual arrangements with Medicaid MCOs to manage a population of Medicaid members under a risk adjusted total cost of care arrangement. The Coordinated Care Pilot offered two tracks:

- **Type 1 Coordinated Care Pilot: Total Population, All Services:** This track offered an opportunity to contract for all Medicaid attributed populations, for all Medicaid services.

- **Type 2 Coordinated Care Pilot: All Services to Populations of Persons with Severe and Persistent Mental Illness (SPMI)/Severe Mental Illness (SMI):** This track offered an opportunity to contract for a specialized Medicaid population, for all Medicaid services. Type 2 pilots were only established for persons with SPMI or SMI.

AEs are expected to develop and prove competency in two priority areas: 1. Integration and coordination of long-term services and supports; 2. Physical and behavioral health integration. Experience from the Coordinated Care Pilot Program will inform certification standards for Medicaid AEs. AE certification is discussed under Years 2-4: Implementation, below.

Medicaid also developed incentive payment programs for hospitals and nursing homes under the Rhode Island Health Transformation Program (RIHTP).

Medicaid has adopted language developed by OHIC which defines APMs and specifies the types of payment models which shall be credited toward each insurer's APM targets. They have developed certification standards for Medicaid AEs. Medicaid MCOs are expected to contract with AEs on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state.

Rhode Island does not prioritize one APM over another. However, given the focus of using healthcare payment to improve overall efficiency, clinical quality, and support whole person care, and to meet an ultimate target of 50% of medical payments by 2018, total cost of care budget models will invariably play a crucial role.

Years 2-4 (Implementation)
Rhode Island is poised to significantly advance the use of multi-payer VBP and APMs through the implementation period of the SIM grant. AEs must demonstrate the capacity to integrate and manage the full continuum of physical and behavioral healthcare, from preventive services to hospital based and long-term services and supports. AEs must also focus on the social determinants of health among their attributed populations. The AE contracting mechanism will be one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018. Managed care procurement, contracting, and Accountable Entity accreditation are three crucial purchasing and regulatory levers that will drive achievement of Rhode Island's payment reform targets.

OHIC will track commercial insurer compliance with their annual APM targets on a semi-annual basis. In addition to semi-annual reporting of APM use, OHIC will require each insurer to develop plans for engagement of specialists in VBP arrangements, including the development of APMs for high volume specialties and specialty care practices. These requirements build on extant rules that obligated insurers to have quality improvement programs with hospitals and tie hospital fee increases to quality performance.

In September of each year, OHIC will administer a survey to primary care practices to assess achievement of the PCMH cost containment strategies. OHIC will also collect data on clinical quality performance measures. These elements will be combined to produce a list of practices sites and associated clinician rosters who have met the OHIC definition of PCMH.

OHIC will assess compliance with commercial insurer payment reform targets, care transformation requirements, and hospital contracting requirements in the context of the annual rate review process in 2017, 2018, and 2019. The Commissioner may consider each insurer's efforts to meet the delivery system and payment reform targets as a factor in her

decision to approve, modify, or reject any regulatory filing. OHIC will publish public reports on insurer compliance with the annual APM and PCMH targets.

Continued Engagement of Payers and Providers

Engagement of payers and providers around payment reform is important for our success. During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation. With an eye toward process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole. As noted above, Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an APM by 2018, and 80% of payments linked to value.

Exploring Alignment with Medicare's Quality Payment Program

On April 27th, CMS released proposed rules implementing the Quality Payment Program (QPP). The QPP implements key provisions of the Medicare Access and CHIP Reauthorization Act (MACRA). To ensure that Rhode Island understands the implications of QPP and to explore the alignment of existing SIM initiatives with QPP, Rhode Island will embed these discussions in existing stakeholder processes once a final rule is promulgated. The Health Insurance Commissioner will put alignment with QPP on the agenda of her Alternative Payment Methodology Advisory Committee in the fall of 2016. **We aim to leverage our SIM investments and regulatory and purchasing initiatives to prepare providers in Rhode Island for the QPP.** We are also currently pursuing conversations between Medicaid and the commercial health plans around participation in CPC+, which feeds into CMS's draft QPP rule.

Tracking System Transformation

In order to track the progress of system transformation, Rhode Island has committed to tracking and publishing information on the use of APMs and VBPs across payers and provider participation in PCMHs and ACOs. The following table shows the key metrics for tracking the progress of system transformation.

Table 17: Key Metrics for Tracking Progress of System Transformation

Metric Title	Data Source	Reporting Frequency	Definition
Payments made under alternative payment models (Commercial Insurers) - APM Categories 3 + 4	OHIC	Annual	Percentage of fully insured commercial medical payments made under an alternative payment model (APM)

Members attributed to total cost of care alternative payment models (Commercial Insurers) - APM Categories 3 + 4	OHIC	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.
Payments made under Value-based payment models (Commercial Insurers) - APM Categories 2 +3 + 4	OHIC	Annual	Percentage of fully insured medical payments tied to value
Payments made under alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments made under and APM
Members attributed to total cost of care alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.
Use of Value-based payment models (Medicaid MCOs) - APM Categories 2 +3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments tied to value
PCPs participating in ACOs	OHIC	Annual	% of network PCPs participating in ACOs and who are attributed patients for whom they are assuming clinical and financial accountability
PCPs practicing in PCMHs	OHIC	Annual	% of network PCPs practicing in PCMHs
Commercial members attributed to PCMHs	OHIC	Annual	% of commercial insured members attributed to a PCMH
Medicaid members attributed to PCMHs	EOHHS	Annual	% of Medicaid MCO members attributed to a PCMH

2: Multi-Payer Reform Using Workforce Development and HIT

Support for multi-payer payment reform and delivery system transformation with investments in workforce development and health information technology.

Despite significant investments in healthcare system transformation from payers, providers, community non-profits, and the state, as well as preliminary steps to transition toward value-based payment models that support that transformation, there still exist gaps in health information technology, data analytics, and workforce supports to achieve the Rhode Island vision outlined above.

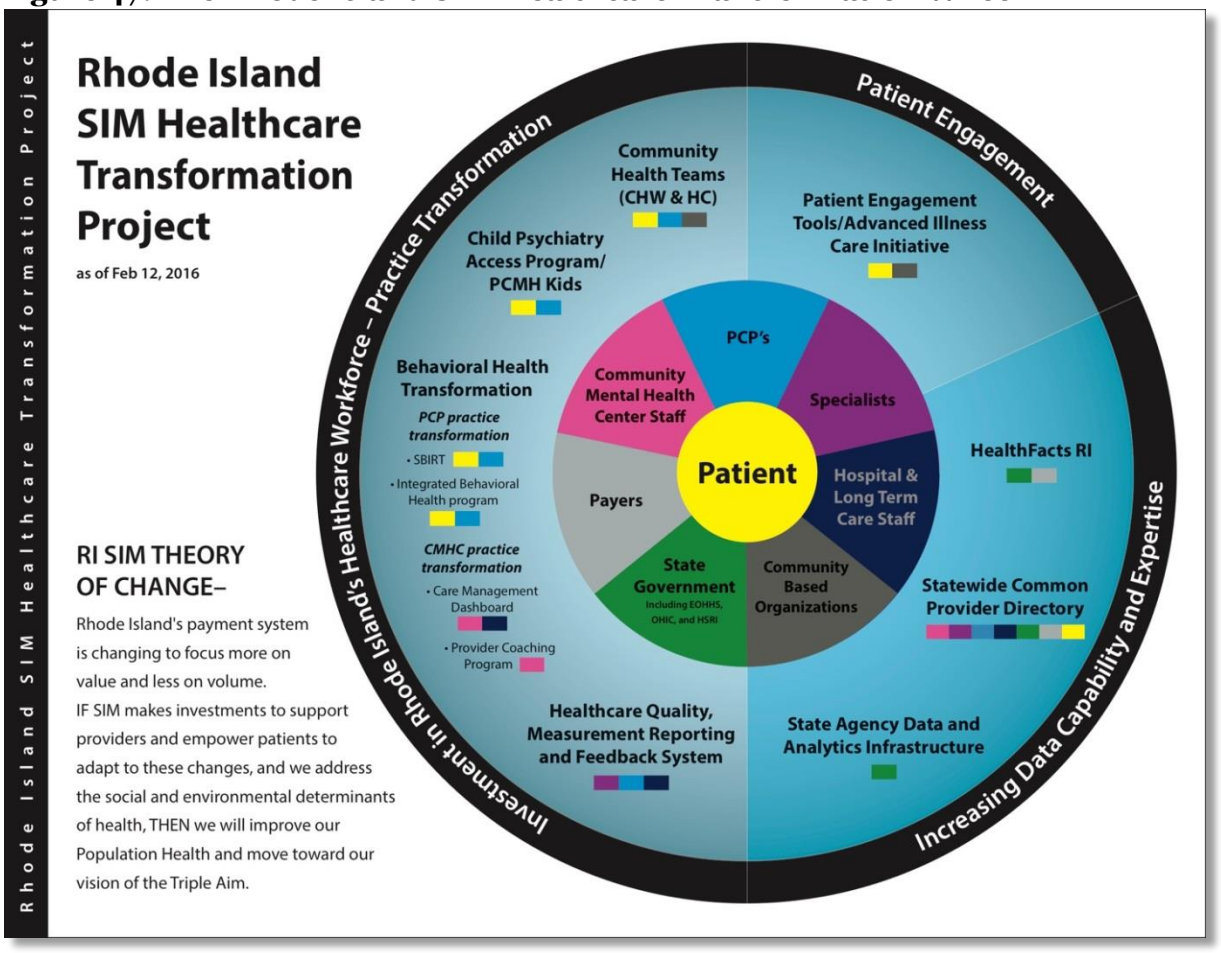
Year 1 - Pre-Implementation

During year one of the grant, the SIM Project Director met with each member of the SIM Steering Committee. The purpose of these meetings was to ascertain where the greatest needs are, and how SIM investments could best address those needs. The question of how Rhode Island should allocate SIM funds presented a choice between going "narrow and deep" or "wide and thin." Through a lengthy and iterative process of consensus building, the SIM Steering Committee endorsed three interconnected buckets of SIM program investment:

- Investment in Rhode Island's Healthcare Workforce – Practice Transformation;
- Investment in Patient Engagement; and
- Investment in Increasing Data Capability and Expertise.

The investments within each of these buckets address a critical need, which will facilitate payment reform and delivery system transformation. Figure 3, known among SIM stakeholders as "The Transformation Wheel" illustrates the portfolio of SIM investments authorized by the SIM Steering Committee.

Figure 47: The Rhode Island SIM Healthcare Transformation Wheel



Supporting healthcare providers at all levels with practice transformation activities is critical to building a sustainable healthcare system that meets patient needs and pursues improved population health as its outcome. Rhode Island has a mature multi-payer patient-centered medical home (PCMH) program and a strong commitment to support primary care. Given that primary care providers have assumed greater accountability for improving system performance and population health, the investments in the practice transformation bucket are intended to provide support for drawing linkages between patient care and community resources (Community Health Teams), access to expertise outside of the primary care office (through the Child Psychiatry Access Program), transformation assistance for behavioral health providers, and a technology platform for collecting clinical data and reporting measures to payers. All of these activities are meant to ensure that providers can work to the top of their licenses and experience more job satisfaction. SIM has convened several workgroups in this area in order to further define these areas of practice transformation and to ensure that SIM-funded resources are coordinated and not duplicative of private sector resources.

There was broad agreement among the SIM Steering Committee that patient behavior was a critical piece of the overall project. In discussions about our Driver Diagram, certain

assumptions about patient behavior undergirded the causal pathways from interventions and drivers to program aims. Patients must become active agents in their health and healthcare. To support patient agency, the SIM Patient Engagement Workgroup began holding meetings in year one to determine the tools and information necessary to meet this goal.

Data analytic capacity and expertise is absolutely critical to improving and evaluating healthcare system performance. The SIM Steering Committee authorized investments in HealthFacts RI (Rhode Island's all payer claims database), a statewide Common Provider Directory, and infrastructure enhancements to Rhode Island's Data Warehouse.

Pre-implementation activities for the above areas of practice transformation, patient engagement, and data analytic capacity and expertise include convening workgroups and stakeholder meetings to ensure proper allocation of resources and community buy-in, working through the state procurement system to buy services as appropriate, and developing metrics to measure success for each of these investments. The procurement of funds for HealthFacts RI and the Common Provider Directory has happened, and the funds began flowing to these projects in year one.

Years 2-4 - Implementation
In year two, Rhode Island will procure the services and structures necessary to carry out the remaining activities enumerated in the Wheel (See Master Timeline on Page 25). Rhode Island plans to apply the following principles to the implementation of these activities:

- Ongoing evaluation, including mid-course adjustments as necessary;
- Flexibility in the design and implementation of these activities to account for potential changes to the health care environment; and
- Continued stakeholder engagement among governmental agencies and private sector participants, including providers, payers, and community organizations.

Practice Transformation
During Years 2-4, Rhode Island will continue to strengthen its health care workforce and the connection of that workforce to the community through the practice transformation initiatives outlined in the Wheel. The workgroups mentioned in the Year 1 Pre-Implementation phase will continue and be used for community feedback.

- Community Health Teams;
- Child Psychiatry Access Program;
- Behavioral Health Transformation; and
- Health Care Quality, Measurement Reporting and Feedback System.

Patient Engagement
In order to fully transform our healthcare system, we must engage patients and consumers in the involvement in their own care, enabling them take control of their health care. This means they will be active members of their health care team, actively participate in the creation and implementation of their care plans, and actively self-manage their chronic conditions and health behaviors. We have identified that one critical gap in patient engagement activities in the state involves patients, families and caregivers dealing with advanced illness and/or end-of-life care and will devote a portion of our patient engagement activities to supporting those individuals, as described on Page 52 above.

The Patient Engagement Workgroup has convened and agreed to define patient/consumer/family engagement, identify the current state and gaps of Rhode Island's

engagement activities, and recommend areas for investments to the SIM Steering Committee. This work will be carried out during the beginning of Year 2, with implementation of accepted recommendations to occur in Years 2-4.

Data Analytic Capacity and Expertise

We know that analytic capacity and expertise is absolutely critical to improving and evaluating healthcare system performance. In years 2-4, SIM state staff will continue to implement the four SIM components that will provide the data analytic capacity and expertise required to measure and inform our transformation efforts. These include maintaining and issuing reports and data from HealthFacts RI (the all payer claims database); completing the build of the provider directory and making its data available to state agencies, healthcare organizations, providers, and consumers in the form of aggregate files and a user-friendly website; and integrating data across EOHHS agencies in a state data ecosystem and driving policy with those data.

3: System Transformation Using Stakeholder Engagement

In Rhode Island, healthcare delivery system transformation is a public-private partnership. There is significant stakeholder engagement in policy development and SIM investments through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups.

Rhode Island has a long tradition of stakeholder engagement in policy development. The state's small size enables key stakeholders to physically convene on a regular basis and with relatively little cost. Healthcare reform in Rhode Island has benefitted greatly from this tradition. Under the leadership of then-Lieutenant Governor Elizabeth Roberts (who now serves as Secretary of the Executive Office of Health and Human Services) the Rhode Island Healthcare Reform Commission stewarded a process of lengthy public engagement around Affordable Care Act implementation. The Healthcare Reform Commission infrastructure was leveraged during Rhode Island's State Innovation Model Design phase, and supplemented by topic-specific workgroups, developed the State Health Innovation Plan (SHIP) which served as the basis of Rhode Island's State Innovation Model Test Proposal.

Year 1 -Pre-Implementation

Rhode Island's SIM project relies on significant stakeholder engagement to achieve consensus on where our healthcare system's needs are, and how we can best address those needs. During year one of the grant, the SIM Steering Committee met seven times and reached consensus on a portfolio of SIM funded investments for the life of the grant. The Steering Committee also endorsed several workgroups to advise or develop specific products within the grant. These workgroups include:

- Integrated Population Health Plan
- Measure Alignment
- Technology Reporting
- Patient Engagement

In addition, SIM is working with two community groups that have brought stakeholders together to focus on Community Health Teams and Provider Practice Transformation. Rather than form our own competing workgroups that would bring people to duplicative meetings, we have asked these community organizations to allow Healthy Rhode Island to put topics on these workgroups' agendas and have them serve as our touchpoints on these issues. Workgroups have been an effective mechanism for processing the needs and goals of the larger community and achieving buy-in for specific investments and initiatives.

Years 2-4 -Implementation
All of these workgroups will continue through year two of the grant. The Integrated Population Health Workgroup will continue to meet on a quarterly basis, to check in on the progress toward population health improvement goals. The Technology Reporting Workgroup will continue to refine the scope of the Quality Measurement, Reporting and Feedback System for procurement by the state. The Patient Engagement Workgroup will continue to meet to assess the tools necessary to equip consumers with information to become effective consumers of health care. The Measure Alignment Work Group is discussed at length in that specific section. We may create additional workgroups in year two, including a group on Workforce Development.

4: Transformation Using Population Health Planning

Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved physical and behavioral health.

Rhode Island has committed to improving the physical and behavioral health of its residents. The Integrated Population Health Plan provides a philosophy and a set of recommendations for stakeholders, including state agencies, to ensure that policymaking and delivery system transformation are in agreement with our vision for improved population health. Rhode Island understands that much of what determines health is contingent on factors outside of medical care delivery. However, as payment models change to enable and incent system transformation, stakeholders should assess whether these models and structures are supporting improvements in the health of the population and communities served by the system. In the long-term evaluation of dental and vision with respect to population health may be required.

Year 1 -Pre-Implementation
In year one Rhode Island developed the Integrated Population Health Plan, included as a separate document to this Operational Plan. The Integrated Population Health Plan was completed with considerable guidance from the Rhode Island Department of Health and the Department of Behavioral Health, Developmental Disabilities and Hospitals.

RIDOH, which oversees the state's certificate of need (CON) program, has explicitly incorporated the following agency priorities into its guiding principles to review CON applications:

- Address social and environmental determinants of health;
- Eliminate disparities of health and promote health equity;
- Ensure access to quality health services for all Rhode Islanders, including vulnerable populations.
- Consider affordability, accessibility, and innovation.

See Appendix 3 for RIDOH's Guiding Principles letter, which lays out specific recommendations for the CON program to use to evaluate new hospital or equipment proposals.

Years 2-4 - Implementation
SIM will continue to work with its partner agencies to expand on the Integrated Population Health Plan. We see it as a living document that will grow and adapt to modifications in policies or regulatory levers, changes in our overall population health, or to accomplishments of our SIM projects.

The SIM structure – with both interagency and public/private participation and our evaluation plan – will give us the platform and the flexibility to return to the Integrated Population Health Plan on a regular basis for review. We will measure the accomplishments of our work against its baseline and use its information to guide SIM decision-making.

For more information on aligned population health planning, see the Current State and Future Goals Section on Page 138.

5: Multi-Sector/Multi-Agency Alignment and Integration

One of the main strategies of Rhode Island's SIM project is to reach a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This will allow us to build on current achievements, expand the reach of these initiatives, avoid duplication of funding, and, we expect, save money.

Year 1 (Pre-Implementation)

In collaboration with the Integrated Population Health Plan consultants, SIM is in the process of mapping existing and planned interventions with new SIM investments. For examples of several already identified areas for collaboration, see Page 195 in the Operational Plan. For a detailed chart of aligned programs, see Table 16 of the Integrated Population Health Plan.

Years 2-4 (Implementation)

We are embedding alignment opportunities in the procurement and implementation of all SIM investments. Also, because of the multi-sector nature of the SIM process, our partners will continue to identify new areas for collaboration.

Leveraging Regulatory Authority

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work. The following provides an overview of the key state regulatory levers that are currently being used, or plan to be used, to drive system transformation. As the SIM project progresses, the state interagency team will work with additional agencies (e.g. Department of Children, Youth, and Families, Rhode Island Department of Education, and Rhode Island Department of Transportation) to determine the appropriate usage of their regulatory levers. The structure of the SIM staff team, where staff are embedded in their respective agencies, allows the SIM project to effectively use the state's regulatory levers to advance the SIM goals.

Executive Office of Health and Human Services

The Executive Office of Health and Human Services (EOHHS) is the home of the SIM grant. EOHHS comprises the state Medicaid agency, the Department of Human Services, the Department of Health, the Department of Behavioral Health, Developmental Disabilities and Hospitals, and the Department of Children, Youth and Families.

Medicaid

The Medicaid program possesses regulatory and purchasing levers that are critical to the success of Rhode Island's Healthcare Transformation Plan. The ability of Medicaid to contract directly with providers or with health plans to assume risk for the Medicaid population grants the program significant leverage to shape the healthcare delivery system.

Currently, Medicaid contracts with Managed Care Organizations (MCOs) and pays them a capitated rate for Medicaid enrollees across different programs. In turn, Medicaid imposes conditions on the MCOs through contracting. The contracting conditions structure how MCOs reimburse providers, measure quality, and support multi-payer programs, such as the state's multi-payer patient-centered medical home program. As stated in the Rhode Island Healthcare Transformation Plan, Medicaid will use the MCO purchasing and contracting mechanism to require specific annual targets for use of APMs by the MCOs, and directives to contract with credentialed Medicaid Accountable Entities. Medicaid also controls provider reimbursement rates for its population and is designing incentive payment programs for hospitals and nursing homes.

As discussed further in the Healthcare Delivery System and Payment Transformation Plan, Medicaid is leading an Accountable Entities (AE) Coordinated Care Pilot Program which will allow credentialed AEs to enter into arrangements with MCOs that manage a specific population of Medicaid members under a risk-adjusted total cost of care contract. This regulatory lever will be used to meet the following high-level set of metrics, which are aligned with the SIM payment reform goals:

- By 2018, 90 percent of Medicaid payments to providers will have some aspect that is tied to quality or value
- By 2018, 50 percent of Medicaid payments will be made through an "alternative payment model," including payments to Accountable Care Organizations, bundled payments, or others.

- By 2018, 25 percent of Medicaid members will be enrolled in an accountable integrated provider network.

These Medicaid payment reform goals, combined with the statement that AEs should be PCMH-based (at least 50% of the AE's attributed members must be enrolled in a qualified PCMH as defined by the Office of the Health Insurance Commissioner) are actively moving Rhode Island's healthcare system towards value-based purchasing and towards achieving the Triple Aim.

Department of Health

The Rhode Island Department of Health (RIDOH) maintains primary responsibility for the interests of life and health among the peoples of the state. RIDOH is the lead agency for investigations into the causes of human disease, the prevalence of epidemics and endemics among the people, the sources of mortality, the effect of localities, employments and all other conditions and circumstances on the public's health. RIDOH is charged with ascertaining the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health. RIDOH is responsible for the adoption of proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state.

RIDOH publishes and circulates, from time to time, information that the Director may deem to be important and useful for dissemination among the people of the state. With no local health departments within the state, RIDOH provides advice in relation to those subjects relating to public health that may be referred to it by the general assembly or by the governor when the general assembly is not in session, or when requested by any city or town. RIDOH adopts and promulgates rules and regulations that it deems necessary to carry out the responsibility invested in the agency. The overall scope of RIDOH's roles and responsibilities includes, but is not limited to: health planning, vital records, immunization, facilities regulation, healthcare professional licensing, vital records, disease outbreak response, food and water safety, laboratory testing, and other aspects of health promotion.

RIDOH also regulates the Health Information Exchange and All Payer Claims Database as described in more detail in the Health Information Technology Plan. RIDOH has statutory authority to require public reporting by any of its licensed professionals and facilities. Leveraging the public reporting authority beyond current programs will require regulatory changes. We will consider and discuss with stakeholders any regulatory changes that will help further our SIM goals.

RIDOH, in conjunction with BHDDH, leads the development of the Integrated Population Health Plan, a key component of Rhode Island's SIM project. For the development of the Integrated Population Health Plan, RIDOH will continue to leverage its ability to collect and report on relevant data, in addition to leveraging its authority to implement initiatives that will improve physical and behavioral health for the state's residents.

Additionally, as the SIM project progresses and if appropriate, RIDOH may choose to use its regulatory levers around community benefit requirements, licensing, boards, and scope of practice, complaints investigation health planning (e.g., managed care, certificate of need, healthcare utilization review), emergency medical services, and facilities regulation to coordinate efforts to streamline Rhode Island's healthcare delivery system. For example, licensing requirements for some programs within healthcare academic institution (i.e., hours needed for completion) can be set by RIDOH. In some cases, with nursing and nursing assistant programs, the professional boards set some, if not all, of the curriculum through the Center for Professional Boards and Commissions. Other administrative authority may include changes to

e-licensing or auto-enrolling in e-prescribing systems, licensing-fee incentives, and continuing education leers for specialized topics.

Department of Behavioral Health, Developmental Disabilities and Hospitals

Under Rhode Island General Laws, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) is responsible for providing services to persons with mental illness and substance abuse, developmental disabilities and chronic, long-term medical and psychiatric conditions. The Department serves more than 50,000 persons per year through State personnel as well as community providers. BHDDH holds oversight, quality assurance and patient protection responsibilities for providers under state licensing regulations.

Medicaid reforms have been changing both mental health and substance use service delivery in the state. Health Homes serve: 1) persons with opioid use disorders and 2) individuals with severe and persistent mental illness (SPMI) and severe mental illness (SMI). (See Page 198 for more information.)

In a recent contractual change, two MCOs now oversee payments to Community Mental Health Organizations (CMHOs) who serve as Health Homes for persons with SPMI or SMI conditions. Bundled Medicaid rates have been established for levels of care based on acuity with a focus on consumer outcomes.

A planning grant initiative has begun to credential the CMHOs as Certified Community Behavioral Health Clinics (CCBHCs) and to develop a Prospective Payment System, per the Federal Protecting Access to Medicare Act, 2014. Rhode Island will submit an application in October, 2016 requesting funding for the two-year Federal pilot program that will bring to awardee states a 90%/10% matching rate and enable qualified providers to offer more comprehensive, robust mental health and substance use services.

BHDDH's programs and regulatory levers support the core elements of Rhode Island's Healthcare Delivery System Transformation Plan. Through its contracting authority, BHDDH is promoting the use of value-based payment models for the SPMI/SMI population. The programs and levers also address key component health areas of our Integrated Population Health plan, including serious mental illness and opioid use disorder.

BHDDH's programs and regulatory levers support the core elements of Rhode Island's Healthcare Delivery System Transformation Plan. Through its contracting and credentialing authority, BHDDH is promoting the use of value-based payment models (e.g. bundled payments) for the SPMI/SMI population and developing credentialing standards for CMHOs that will further the goals listed in Rhode Island's SIM project. Additionally, the focus of Health Homes on the SPMI/SMI population specifically addresses one of the health focus areas outlined in the Integrated Population Health Plan and will serve as a way to promote more coordinated, efficient care which will advance Rhode Island's delivery system transformation efforts.

Office of the Health Insurance Commissioner

Pursuant to RIGL §42-14.5-2 (4)-(5), the Office of the Health Insurance Commissioner (OHIC) has a statutory mandate to direct health insurers toward policies and practices that improve the health care system as a whole. It has a number of regulatory levers that it has been using for years to help push changes in our healthcare system toward value rather than volume. Now, working with Medicaid, the two agencies together are able to use their authority to significantly advance the SIM Test Grant's work.

OHIC exercises prior approval Form and Rate Review authority for the individual, small group, and large group markets. As of April 2015, 232,297 people obtained insurance coverage through these markets. The annual review of health insurance forms and rates places critical scrutiny on the factors underlying medical trend, insurer administrative costs, and insurer financial strength.

OHIC also leverages its rate review authority and statutory mandate around system transformation to impose a set of initiatives to improve the healthcare system and support more affordable health insurance. These standards, known as the Affordability Standards, comprise three major elements:

- Standards to advance value-based purchasing;
- Standards to promote practice transformation and increase financial resources to primary care for population health management; and
- Standards around hospital contracting.

OHIC uses its rate review authority and statutory mandates to work with stakeholders (payers, providers, businesses, and consumers) to develop annual plans that increase the adoption of value-based purchasing models and patient-centered medical homes. OHIC's regulatory levers as related to SIM are discussed in further detail in the Healthcare Delivery System Transformation Plan and SIM Alignment with Federal and State Initiatives sections. See Page 168 for Rhode Island's System Transformation Plan.

HealthSource RI

HealthSource RI (HSRI) is Rhode Island's health insurance exchange, providing insurance to 35,000 Rhode Islanders. The regulatory levers they command in order to help institute payment reforms throughout Rhode Island's healthcare system including the following:

- HSRI Qualified Health Plan certification for individual and small group products—By coordinating with OHIC, EOHHS, and carriers, HSRI can actively solicit plans that advance payment reforms, such as plan designs that promote the use of patient-centered medical homes or plan designs that advance value-based payment models through provider contracting.
- HSRI consumer education efforts—Empowering consumers to make better healthcare choices, both in choosing plans and when using services. HSRI's experience with consumer education is pivotal to SIM's patient engagement initiative and to improving patients' overall experience of care.
- HSRI is currently exploring and analyzing the feasibility of providing coordination of state employee health plans in an effort to achieve alignment of benefits and incentives for delivery system reform across another population within Rhode Island.

Aligning Regulatory Levers to Counter Fragmentation

As noted elsewhere in this plan, SIM has facilitated the alignment of OHIC and Medicaid around regulations that move our health system from volume to value. Medicaid's regulations for its Accountable Entities match those of OHIC's for the commercial market, which is important because the same carriers provide coverage in both markets.

Through our Integration & Alignment Project, we aim to expand these types of collaborations to strengthen the ability of the state to achieve our goals, and to make it easier for those entities regulated by the state to follow an aligned set of rules.

SIM will also work with other state partnerships to maximize alignment and counter fragmentation. For example, the Rhode Island Children's Cabinet plays an important role in ensuring positive health and safety outcomes for children and youth in Rhode Island. Committed to strengthening the collective impact of state agencies serving children, youth and families, Governor Raimondo and the state agency directors who sit on the Cabinet have recently convened a cross agency work group to map children's behavioral health services, funding streams and regulatory/governance structures. Keenly aware of the operational demands of the SIM population health plan, the Cabinet prioritized assessing these items now so that the policy and implementation recommendations yielded by the SIM team can be adequately and appropriately supported by a governance structure and service continuum that is accessible and responsive to Rhode Island's children, youth and families.

Quality Measure Alignment

Quality measurement and improvement are integral components of value-based contracting. As we pursue our target of having 80% of payment linked to value and value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, in June 2015, the SIM Steering Committee charged a workgroup comprised of payers, providers, measurement experts, consumer advocates, and other community partners to develop an aligned measure set for use across all payers in the state.

Quality Measure Alignment Process

Because of SIM Steering Committee Chairman Lou Giancola's support for this process, he worked with the Hospital Association of Rhode Island, Blue Cross Blue Shield of Rhode Island, UnitedHealthcare of New England, and Neighborhood Health Plan of Rhode Island to raise the funding to hire Michael Bailit and his team at Bailit Health Purchasing to consult on this process. The Bailit team provided technical and facilitative support to the workgroup.

Michael Bailit has supported multiple state efforts that measure alignment in addition to its current work in Rhode Island with the SIM Measure Alignment Work Group. Past projects with multi-payer measure alignment include completed projects for the states of Maine, Oregon, Pennsylvania, Vermont, and Washington. Bailit has also assisted with measure set development for the states of California, Colorado, Massachusetts, and Missouri. For some of these projects, he has supported state work by using the Measure Selection Tool that it developed with Robert Wood Johnson Foundation funding for the Buying Value project.

Year 1 - Pre-Implementation

The Measure Alignment Workgroup held 12 meetings between July 2015 and March 2016. The goal that the workgroup set for itself was to develop a menu of measures from which payers could pick, and specific core sets of measures to be included in all contracts. At the outset, the workgroup adopted 11 criteria for measure selection:

1. Evidence-based and scientifically acceptable;
2. Has a relevant benchmark (use regional/community benchmark, as appropriate);
3. Not greatly influenced by patient case mix;
4. Consistent with the goals of the program;
5. Useable and relevant;
6. Feasible to collect;
7. Aligned with other measure sets;
8. Promotes increased value;
9. Presents an opportunity for quality improvement;
10. Transformative potential; and
11. Sufficient denominator size.

The workgroup used the measure selection criteria to assess the relative merits of including measures in the menu and core sets. Measure selection criteria were also used to score designated measures for a second round of review.

The workgroup reviewed existing measures used in value-based contracts between payers and providers in Rhode Island. These measures were cross-walked to the CMS Medicare Shared Savings Program and 5-Star measure sets to assess alignment using the Buying Value Tool. The measures were also cross-walked to SIM population health priorities, including diabetes, obesity, tobacco use, and hypertension. Measures were grouped by domain, including preventive care, chronic illness care, institutional care, behavioral health, overuse, consumer experience, utilization, and care coordination. The measures represented a mix of claims-based measures, and measures based on clinical data, or a combination of claims and clinical data. The measure review process took several months to complete, as each measure was given individual consideration. Workgroup members were also asked to submit measures for consideration by the workgroup that were not currently used in contracting.

The final product was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). Core measures are required to be in all performance-based contracts of the relevant type: primary care, hospital, ACO. Beyond the core measures, health plans and providers may select measures from the menu for inclusion in contracts. The Measure Alignment Workgroup was silent on whether measures shall be used for payment only, vs. payment and/or reporting. Specific targets and incentives associated with the measures will be left up to negotiation between the health plans and providers.

Years 2-4 - Implementation

Two concurrent processes will occur during the implementation period. First, during year two, OHIC and EOHHS will develop a regulatory framework to mandate use of the core measure sets and adherence to the measure menu by regulated insurers. OHIC will issue regulations covering commercial insurers and EOHHS will incorporate the measure sets into its MCO contracts. The state will also develop a formal group to refine the menu and core sets over time. Due to changes in clinical standards, retirement of existing measures and introduction of new ones, and changing public health priorities, the measure review group will meet annually to refine the measure set.

In year two, the SIM team will also initiate a series of specialized Workgroups to align measures for specialty providers. The tentative schedule is to review measures for behavioral health providers, maternity care, cardiology, and orthopedics. For the latter two specialties, Rhode Island is awaiting further articulation by CMS of how the recently developed CMS Core Measure Set will be used. The Workgroups will meet on a regular basis, facilitated by Michael Bailit, as they did with the original process – to analyze the measures and propose a set for acceptance by the SIM Steering Committee.

Once the Health Care Quality Measurement, Reporting and Feedback System is built, Rhode Island may scale the system to facilitate public reporting on the core measures. Please see Page 227 for a more detailed description of the Reporting and Feedback System, and how we envision it collecting data from a variety of sources, ideally leveraging existing infrastructure, collecting and mastering the data within a data intermediary, and analyzing and viewing those data through an analytics engine with external public and provider facing website.

Aligned Measure Sets

SIM Aligned Hospital Measure Set
Total Measures: 20

Core Measures by Domain (6)
Behavioral Health (1)
- Follow-Up After Hospitalization for Mental Illness (7-day)

Consumer Experience (1)
- HCAHPS - *questions not specified*

Institutional Care (4)
- Follow-Up After Discharge from ED for Mental Health or Substance Abuse
- HAI-2: CAUTI: Catheter-Associated Urinary Tract Infection
- HAI-6: Clostridium Difficile (C.diff.) Infections
- READM-30-HOSP-WIDE: Hospital-wide Readmission

Menu Measures by Domain (14)
Behavioral Health (1)
- 30-day Psychiatric Inpatient Readmission

Care Coordination (1)
- Care Transition Record Transmitted to Health Care Professional

Institutional Care (12)
- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
    - HAI-3: SSI: Colon - Surgical Site Infection for Colon Surgery
    - HAI-4: SSI: Hysterectomy - Surgical Site Infection for Abdominal Hysterectomy
- Cesarean Rate for Nulliparous Singleton Vertex (PC-02)
- Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)
- HAI-1: CLABSI: Central Line-Associated Blood Stream Infection
- HAI-5: Methicillin-resistant Staphylococcus Aureus (or MRSA) Blood Infections
- PC-05: Exclusive Breast Milk Feeding
- READM-30-AMI: Heart Attack Readmission
- READM-30-HF: Heart Failure Readmission
- READM-30-PN: Pneumonia Readmission
- STK-4: Thrombolytic Therapy
- SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge
- Transition Record with Specified Elements Received by Discharged Patients

SIM Aligned ACO Measure Set
Total Measures: 59

Core Measures by Domain (11)
Behavioral Health (2)
- Follow-Up after Hospitalization for Mental Illness (7-day)
- Screening for Clinical Depression and Follow-Up Plan

Chronic Illness (2)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- Controlling High Blood Pressure

Consumer Experience (1)

- PCMH CAHPS (for primary care) - *questions not specified*

Preventive Care (6)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Tobacco Use: Screening and Cessation Intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
- Developmental Screening In the First Three Years of Life
- Adult BMI Assessment

Menu Measures by Domain (48)

Behavioral Health (5)

- 30-day Psychiatric Inpatient Readmission
- Anti-Depressant Medication Management
- Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia – *Medicaid only*

Care Coordination (1)

- Care Transition Record Transmitted to Health Care Professional

Chronic Illness (5)

- Medication Management for People with Asthma
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Consumer Experience (3)

- ACO CAHPS - Access to Specialist
- PCMH CAHPS (for primary care) - *questions not specified*
- HCAHPS - *questions not specified*

Institutional Care (16)

- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
    - HAI-3: SSI: Colon - Surgical Site Infection for Colon Surgery
    - HAI-4: SSI: Hysterectomy - Surgical Site Infection for Abdominal Hysterectomy
- Cesarean Rate for Nulliparous Singleton Vertex (PC-02)
- Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)
- HAI-1: CLABSI: Central Line-Associated Blood Stream Infection
- HAI-2: CAUTI: Catheter-Associated Urinary Tract Infection
- HAI-5: Methicillin-resistant Staphylococcus Aureus (or MRSA) Blood Infections
- HAI-6: Clostridium Difficile (C.diff.) Infections
- PC-05: Exclusive Breast Milk Feeding
- READM-30-AMI: Heart Attack Readmission
- READM-30-HF: Heart Failure Readmission
- READM-30-HOSP-WIDE: Hospital-wide Readmission
- READM-30-PN: Pneumonia Readmission
- STK-4: Thrombolytic Therapy

- SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge
- Follow-Up After Discharge from ED for Mental Health or Substance Abuse
- Transition Record with Specified Elements Received by Discharged Patients

Overuse (5)

- Appropriate Testing for Children with Pharyngitis
- Use of Imaging Studies for Low Back Pain
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- PointRight Pro 3.0 30-Day All-Cause SNF Rehospitalization
- Plan (ACO) All-Cause Readmission

Preventive Care (10)

- Cervical Cancer Screening
- Chlamydia Screening
- Adolescent Well Care Visits
- Human Papillomavirus (HPV) Vaccine for Female Adolescents
- Childhood Immunization Status
- Immunization Status for Adolescents
- Lead Screening for Children
- Annual Dental Visits – *Medicaid only*
- Frequency of Ongoing Prenatal Care – *Medicaid only*
- Prenatal and Postpartum Care: Postpartum Care Only

Utilization (3)

- Percentage of Prescriptions that are Generic Scripts
- Inpatient Visits/1000 (Inpatient Utilization - General Hospital/Acute Care)
- ED visits per 1000

SIM Aligned Primary Care Measure Set as of March 10, 2016
Primary Care-Influenced Measures: 34

Core Measures by Domain (7)

Behavioral Health (1)

- Screening for Clinical Depression and Follow-Up Plan

Chronic Illness (2)

- Controlling High Blood Pressure*
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)*

Preventive Care (4)

- Adult BMI Assessment*
- Tobacco Use: Screening and Cessation Intervention*
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents**
- Developmental Screening In the First Three Years of Life**

Menu Measures by Domain (27)

Behavioral Health (5)

- Follow-Up after Hospitalization for Mental Illness (7-day)
- 30-day Psychiatric Inpatient Readmission
- Anti-Depressant Medication Management
- Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Chronic Illness (5)

- Medication Management for People with Asthma
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)*
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Consumer Experience (1)

- PCMH CAHPS (for primary care) - *questions not specified*

Overuse (3)

- Plan (ACO) All-Cause Readmission
- Appropriate Testing for Children with Pharyngitis
- Use of Imaging Studies for Low Back Pain

Preventive Care (10)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Adolescent Well Care Visits
- Human Papillomavirus (HPV) Vaccine for Female Adolescents
- Childhood Immunization Status
- Immunization Status for Adolescents
- Lead Screening for Children
- Annual Dental Visits – *Medicaid only*

Utilization (3)

- Percentage of Prescriptions that are Generic Scripts
- Inpatient Visits/1000 (Inpatient Utilization - General Hospital/Acute Care)
- ED visits per 1000

* CTC-RI measure
** PCMH-Kids measure

SIM Alignment with State and Federal Initiatives

SIM's Multi-Sector/Multi-Agency Integration & Alignment

As noted above, one of the main strategies of the Rhode Island's SIM project is to reach a new level of alignment and integration of our existing healthcare innovation initiatives. As we have described, maximizing the alignment of the state's reform efforts that are already in place and those that SIM is funding will allow us to build on their achievements, expand their reach, avoid duplication of funding, and, we expect, save money.

The list below lays out the initiatives currently underway in Rhode Island that we are aware of, and how our SIM project relates to, aligns with, or augments these efforts. Throughout this plan, we provide examples of how our purposeful focus on alignment can maximize the reach of our health reform activities.

Current CMMI Projects and Awards

Health Care Innovation Awards

The Health Care Innovation Awards are three-year grants that are provided to organizations to implement new ideas in order to deliver better care to Medicare, Medicaid and the Children's Health Insurance Program CHIP recipients. The Rhode Island recipients are presently: Health Resources in Action, Women and Infants Hospital, and the University of Rhode Island. According to the CMMI website,

> *The Health Care Innovation Awards are funding up to $1 billion in awards to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.*

The Health Resources in Action "New England Asthma Innovation Collaborative" (NEAIC) is a multi-state, multi-sector partnership convened by the Asthma Regional Council of New England (ARC). They have created an innovative Asthma Marketplace in New England to increase the supply and demand for high-quality, cost-effective health care services delivered to Medicaid children with severe asthma.

Rhode Island SIM can learn about NEAIC's workforce development activities that are training community health workers focused on asthma treatment and prevention. We have met HRiA staff and will continue to connect with them to explore whether our community health teams can work together and learn from each other, rather than duplicating efforts.

We can also connect with the Partnering with Parents program at Women and Infants Hospital, which is improving services for approximately 2400 families in Rhode Island who have pre-term or high-risk full term babies with a Neonatal Intensive Care Unit (NICU) admission of 5 or more days. The program has hired, trained and deployed Early-Moderate Preterm, Late Preterm, and high-risk Full Term family care teams to offer education and support to parents during the transition from the NICU to home, and monitor infants' growth and development. RHODE ISLAND SIM can also learn from these community health workers and work to align our teams with theirs.

Bundled Payments

Kent Hospital, Newport Hospital, Rhode Island Hospital, The Miriam Hospital and multiple home health agencies are operating with Bundled Payment Models Two and Three, in which payments are structured around an episode of care (Two: Acute and Post-Acute, Three: Post-Acute Episode Only.) While bundled payments are not an explicit part of our SIM Model Test today, we will follow this program to monitor its outcomes.

Multi-Payer Advanced Primary Care Practice (MAPCP) and CPC+

Under this demonstration, fee-for-service Medicare joined the state-based Chronic Care Sustainability Initiative (now called the Care Transformation Collaborative or CTC) multi-payer medical home demonstration. Rhode Island is one of eight states chosen to participate in this unique state-federal partnership, where CMS agreed to join multi-payer demonstrations based on state-designed payment and delivery system reforms.

CTC is a close SIM partner, and we are working together to determine the best set of next steps for pursuing ongoing Medicare participation in the state's multi-payer medical home collaborative. The state is likely to take the first steps towards participating in CMS's new CPC+ program – or to work with CMMI to request that SIM would stand in for Medicare in this payment collaborative.

Transforming Clinical Practice Initiative (TCPI)

The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale practice transformation. The initiative is designed to support more than 140,000 clinician practices nationally over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. TCPI's goals are to:

- Promote broad payment and practice reform in primary care and specialty care,
- Promote care coordination between providers of services and suppliers,
- Establish community-based health teams to support chronic care management, and
- Promote improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

In Rhode Island, the TCPI project is being carried out by the Rhode Island Quality Institute (RIQI). As a Practice Transformation Network, RIQI is in the process of recruiting 1,500 clinicians to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. The network is providing practice transformation assistance, care coordination tools and services, performance measurement, and reporting and evaluation to help participating clinicians meet the initiative's phases of transformation and associated milestones, clinical and operational results.

In their TCPI planning, RIQI aligned their measures to match SIM's (with CMS' approval), and we are in regular contact with RIQI staff to ensure that we are working together as closely as possible to coordinate practice transformation efforts. We will also discuss the low EHR adoption rate with the TCPI leadership. We may find a way to address this by thinking about it together.

As we have noted elsewhere in the Operational Plan, SIM is working with RIQI, CTC, and Healthcentric Advisors to coordinate the physician practice assistance work being carried out by the four projects. Together, we will be using the Statewide Common Provider Directory to track

which practices are receiving assistance, and where there are gaps. This joint practice assistance review is part of our integration and alignment work.

Accountable Health Communities

Rhode Island Medicaid, RIDOH, and SIM have been working together to assist several private sector health organizations apply for funding within the current Accountable Health Communities (AHC) grant application. Two bridge organizations submitted applications by the May 18th CMS deadline – and we hope that at least one of those organizations is chosen. We believe that the aim of the grant – to systematically identify the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries, (including those who are dually eligible), and address their identified needs – will be an important addition to the SIM impact on Rhode Island's Population Health. If one of the bridge organizations is successful, Medicaid will be a part of the AHC collaborative as required. We will ensure that the SIM Steering Committee and other SIM leadership will receive updates throughout the grant process, and that the implementation of the project is tied in as seamlessly as possible to our Community Health Teams.

EOHHS Programs, with Federal and State Funding

Integrated Care Initiative

A recent focus of the State's Medicaid program has been on EOHHS' Integrated Care Initiative (ICI), which is designed to better align the care and financing of Medicare and Medicaid, promote home and community based care, and provide cost-effective care for adults with disabilities and the elderly. During Phase I of the ICI, EOHHS established a capitated Medicaid managed care plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS). There currently are about 21,000 people enrolled in the Medicaid managed care plan established during Phase I.

Under Phase II, Rhode Island will establish a fully integrated capitated Medicare-Medicaid plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage. Federal authority for Phase II is through the Center for Medicare and Medicaid Services (CMS) Financial Alignment Demonstration (FAD), a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. About 10,000-14,000 people are expected to enroll in the Medicare-Medicaid plan.

Medicaid 1115 Waiver

Rhode Island submitted an extension request to its current 1115 Waiver in 2013. The 1115 Waiver was approved in January 2014. The original waiver allowed Rhode Island to operate the entire Medicaid program under a single 1115 demonstration. The RI Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (*1115 Waiver*) established a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The State has used the additional flexibility afforded by the 1115 Waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

The 1115 Waiver has three major program goals: to re-balance the publicly funded long term care system, to ensure all Medicaid beneficiaries have access to a medical home and to implement payment and purchasing strategies that ensure a sustainable, cost-effective program.

The 1115 Waiver savings fell short of promised levels, in part because the State realized that many of the elderly Medicaid recipients who could have been eligible to be transferred out of long term care facilities did not have safe, community-based housing to which they could return. The State recently submitted an extension request with a specific focus on enabling funds to be used to support housing.

Medicaid Health Homes

Although CMS financial support recently ended, Rhode Island continues to support three of these Medicaid innovative complex care delivery models; one is for the pediatric population and builds upon a pre-existing program called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). The other two are adult-focused programs. The Integrated Health Home is for the serious and persistent mentally ill population and is operated by the eight Community Mental Health Organizations licensed by BHDDH. The other adult health home is for persons who are receiving Opioid Treatment, such as Methadone Maintenance and who have or who are at risk of other chronic conditions. This program is operated by the BHDDDH-certified Opioid Treatment Programs. According to CMS, health homes are designed to serve Medicaid enrollees who meet one of the following criteria (Centers for Medicare and Medicaid Services, 2010):

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Early data suggests that families using the CEDARR program have an improved quality of life – and SIM can learn from this data when evaluating our Community Health Teams.

Medicaid Accountable Entities

The Rhode Island Executive Office of Health and Human Services (EOHHS), through the contracted Medicaid Managed Care Organizations (MMCOs) is supporting the development of an Accountable Entities Coordinated Care Pilot program (AEs). This is part of a broader initiative by EOHHS to promote and support the development of integrated multi-disciplinary Accountable Entities (AEs) capable of providing superior health outcomes for Medicaid populations within value based payment arrangements. The pilot program is beginning in April 2016, and will provide a fast-track path for interested organizations to partner with EOHHS and its contracted Medicaid Managed Care Organizations (MMCOs) in transforming the structure of the health care delivery system to reward value instead of volume. Accountable Entity rules are being developed in consultation with the value-based changes undertaken by Rhode Island's Office of the Health Insurance Commissioner (OHIC) so that the two agencies are working together and aligned.

EOHHS intends that certified Accountable Entities will provide the central platform for transforming the structure of the delivery system as envisioned in the Final Report of Rhode Island's Reinventing Medicaid Working Group that was convened by Governor Raimondo in March of 2015.

The core objectives of the AE program include:

- Substantially transition away from fee-for-service models.

- Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Use the aligned measures set created by the SIM stakeholder team.
- Maintain and expand on our record of excellence in delivering high quality care.
- Deliver coordinated, accountable care for high-cost/high-need populations.
- Ensure access to high-quality primary care.
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings.

Medicaid EHR Incentive Program

EOHHS administers the Medicaid EHR incentive program and, as part of that program, has been successfully been receiving 90/10 funding since 2012 to help support the continued development and implementation of RI's statewide Health Information Exchange (HIE), CurrentCare. The Rhode Island Quality Insititute (RIQI), which serves as the state's regional health information organization/and was designated as the state's HIE, implemented a voluntary funding model in 2012 whereby all of the major commercial insurers, a number of self-funded employers including state employees, and Medicaid started contributing $1.00 per member per month based on the number of lives. This funding model has supporting the activities such as onboarding of providers, onboarding additional data submitting partners (including practices sending CCDs) enrollment of individuals into CurrentCare, and some of the very early provider directory design work. Through the EHR incentive program's HIE- IAPD initiative, RI Medicaid was able to obtain 90/10 funding to support this funding model. Given CMS has recently expanded HIE initiatives that are considered to be eligible for 90/10 funding, the State HIT Coordinator and SIM HIT Specialist have been identifying additional HIE projects that may be able to leverage the 90/10 funding and requested technical assistance through SIM with expertise on the topic. These projects if approved are likely to support care transitions, community health teams, patient engagement and additional quality measurement efforts. Some of the options may support additional CurrentCare capabilities and some may be independent of CurrentCare, but all of the efforts will be aligned with the SIM HIT work plan and will be synergistic.

Home Stabilization Services

This EOHHS program focuses on the social and environmental determinants of health. Home Stabilization is designed to provide supports to Medicaid beneficiaries so that they can continue to live in their home. The specific goals of the program include:

1. Promoting living in the community successfully and reducing unnecessary institutionalization,
2. Addressing social determinants of health, and
3. Promoting a person-centered, holistic approach to care.

The State will certify qualified *Home Stabilization* providers who offer a range of time-limited, flexible services to coach individuals in maintaining successful tenancy. The core areas include:

1. Early identification and intervention of behaviors that may jeopardize housing,
2. Education and training on the roles, rights, and responsibilities of the landlord and tenant,
3. Coaching on developing and maintaining relationships with landlords/property managers,
4. Advocacy and linkage with community resources to prevent eviction when housing may be jeopardized,
5. Assistance with the housing recertification process, and

6. Coordinating with the tenant to review, update, and modify his/her housing support plan.

Money Follows the Person

In April 2011, a Money Follows the Person (MFP) demonstration grant was awarded to Rhode Island. This $27 million grant provides Rhode Island with support to achieve its goal of rebalancing the long term care systems. The goals are to support the transition of individuals out of long term care facilities and back into their home through the use of improved home and community-based services as well as to eliminate the barriers and mechanisms in state laws, state Medicaid plans or state budgets that prevent or restrict the flexible use of Medicaid funds. The grant was extended so that the last year of transition will take place in 2018, with the grant officially ending by September 30, 2020.

Adult Medicaid Quality Grant

CMS awarded EOHHS an Adult Medicaid Quality Grant (AMQ) in December 2012 to: 1) develop State capacity in the measurement, analysis, and reporting of health care quality; 2) establish a core set of regularly reported Adult Quality Measures across Medicaid populations and enhance the communication of these measures within and among state agencies and stakeholders; and 3) improve the quality of care delivered to Medicaid members. CMS recently approved a second No-Cost Extension of the grant extending the end date to December 20, 2016.

Accomplishments to date include:

- Established the Analytic & Evaluation Unit to inform program evaluation efforts across EOHHS: increased the capacity to calculate AMQ measures across Medicaid, assessed current data infrastructure and capabilities; and currently working to standardize recipient categories and develop file structures that can link claims from all data sets into more manageable analytical files.
- Completion of a Transitions of Care Quality Improvement Program (QIP) that brought together hospitals and community providers to measure and improve information transfer upon patient discharge.
- Entering final phase of an Antidepressant Medication Management QIP to improve rate of adherence for newly prescribed antidepressant medication.
- Awaiting final report on an Electronic Health Record Project to analyze the feasibility and validity of collecting diabetes screening measures directly from EHRs versus through claims data.

RIDOH Programs

Within the context of SIM, it is critical to align programs that are complimentary and supportive to each other, particularly when addressing any determinant of health (i.e., healthcare). While SIM provides a tremendous amount of resources to build community extensions (e.g., CHTs) from the healthcare setting into the community setting to improve healthcare, it also is a vehicle through which addressing the social and environmental determinants of health can be catalyzed within the healthcare sector. Conversely, the following three programs at RIDOH highlight just some of the aligned work that is focused on starting within the community setting to address the social and environmental determinants of health but then also now extending into the healthcare setting. By complementing SIM in this way, community-clinical linkages are strengthened from both sides of the equation and population health improvement becomes more readily achieved.

Health Equity Zones

Health Equity Zones are contiguous geographic areas that have measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved. Health Equity Zones (HEZs) are designed to achieve health equity by eliminating health disparities using place-based strategies to promote healthy communities. The 11 HEZ Collaboratives are funded with State and Federal dollars in partnership with the Rhode Island Department of Health (RIDOH). The HEZs support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods across five counties statewide, all of which are core focus areas for the Accountable Health Communities grant initiative described above. Drawing on our guiding principles, the HEZ Collaborative is built on meaningful and true engagement of multi-sector key stakeholders working together, and include municipal leaders, residents, businesses, transportation entities, faith leaders, community planners and partners, law enforcement, education systems and health systems, among others.

Certification of Community Health Workers (CHWs)

Certification of Community Health Workers (CHWs) has been identified as a priority for RIDOH and the development of a certification process is well-underway to strengthen and grow this important workforce. Community Health Teams are a central SIM priority, and so this work is critical to SIM's success. In addition to certification, there are several CHW infrastructure building projects in the planning stage that involves a partnership with Rhode Island College to offer the CHW core competency training, support CHW employers, and provide additional opportunities for specialization in focus areas such as behavioral health. (We will include conversations with Medicaid and carriers around credentialing and reimbursement options.) CHWs are frontline public health workers who serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery. Typically, CHWs are non-licensed, gain expertise from life experience and some community/health education. This lack of health professional licensing makes it difficult for CHWs to receive reimbursement for the valuable role they play in improving the health of their community and working with a community health team.

Community Health Network

In their work to connect Rhode Islanders with appropriate clinical and community resources, Community Health Teams have the potential to move the needle on a number of our health focus areas, including tobacco use, obesity, heart disease and stroke. A potential partner in these efforts is the RIDOH Community Health Network. The Community Health Network consists of a coordinated system to provide evidence based and best practice education to activate patients and improve patient skills necessary to self-manage their chronic condition(s). The Community

Health Network is a partnership between multiple evidence-based programs based at RIDOH and within organizations outside of RIDOH that work on chronic disease management. The Community Health Network is building a skilled workforce of expertly trained staff both professional and community health workers who provide disease/self-management programs, chronic disease management programs, and patient navigation. Components of the system include a centralized referral system with secure fax and email to RIDOH; follow up with the patient to assist with access to the CHN resources, and communication back to the practice concerning the patient experience.

Academic Center

RIDOH's Academic Center is a new initiative that aims to achieve excellence in public health practice while producing the next generation of multidisciplinary public health practitioners. This area of focus at RIDOH aligns with the workforce capacity and monitoring component of the SIM initiative. The Academic Center focuses on building a competent public health workforce with subject-matter expertise, researching for new insights and innovative solutions to health problems, and evaluating effectiveness and quality of public health services, all of which advance progress towards improved public health functioning (assessment, policy development and assurance), enhanced public health outcomes, and health equity. Rhode Island's SIM Project and RIDOH's Academic Center can align through strengthening the integration of scholarly activities with public health practice by instilling a culture of learning and innovative implementation along with continuous quality improvement in the areas of practice transformation and population health needs.

BHDDH - Federal SAMHSA Grants

Mental Health and Substance Use Block Grants

Mental Health and Substance Use Block Grants available for all 50 states are non-competitive grants awarded annually to states that provide funding for mental health and substance abuse services. Priorities for BHDDH's Block Grant funds in FY2016-2017 include: 1) adults with serious mental illness, with a focus on reducing unnecessary Emergency Department use, hospital admissions, readmissions and inappropriate lengths of stay; 2) older adults with serious emotional disturbance with a focus on developing a needs assessment and joint action plan with partnership agencies in Rhode Island, including the Division of Elderly Affairs (DEA), Executive Office of Health and Human Services (EOHHS), Community Mental Health Organizations, and the Rhode Island Elder Mental Health Advisory Council; 3) persons with serious mental illness who are homeless and need affordable housing with supportive services that focus on housing retention. Additional focus is directed to helping these individuals gain access to resources to which they are entitled, including Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP). Social Security; 4) persons who have or are at risk of having Substance Use Disorders and/or Serious Mental Illness/Serious Emotional Disturbance; 5) persons who are at risk for tuberculosis; 6) pregnant and parenting women with substance use disorders and their children; and 7) transition age youth/young adults with severe mental illness and co-occurring disorders.

Collaborative Agreement to Benefit Homeless Individuals

Rhode Island Collaborative Agreement to Benefit Homeless Individuals (CABHI) is a three year grant serving 300 persons. The grant supports veterans and individuals experiencing chronic homelessness who have substance use disorders, serious mental illness, or co-occurring mental health and substance use disorders by enhancing the state's infrastructure through ensuring these high risk individuals have access to treatment, permanent supportive housing, peer and recovery supports, and mainstream services. Through this grant, BHDDH and its partners in the community are: 1) improving statewide strategies to address planning, coordination, and integration of behavioral health and primary care services, and permanent housing to reduce homelessness; 2) increasing the number of individuals, residing in permanent housing, who receive behavioral health treatment and recovery support services; and 3) increasing the number of individuals placed in permanent housing and enrolled in Medicaid and other mainstream benefits (e.g., SSI/SSDI, TANF, and SNAP).

Project for Assistance in Transition from Homelessness Program

Project for Assistance in Transition from Homelessness Program (PATH) assists homeless men and women with mental illnesses and co-occurring substance abuse disorders in getting treatment and transition to permanent housing. The program provides community-based outreach, mental health, and substance abuse treatment and other support services throughout the state.

Healthy Transitions

Healthy Transitions is five-year grant, serving 2500 youth and young adults ages 16-25. It focuses on helping persons who are at risk for developing, or who have already developed a serious mental health condition. The implementation communities for this grant are Warwick and Woonsocket. Serving the communities at large in these locales, the grant activities will focus on public awareness of the early warning signs of mental illness in young people and how to take action; active outreach, engagement and referral; access to effective clinical and supportive

interventions; and sustainable infrastructure changes to improve cross system coordination, training, service capacity and expertise. The grant is supported by a Project Director at BHDDH and Youth Coordinator at Department of Children, Youth and Families. This initiative is helping to forward the work of Rhode Island's Children's Cabinet.

Strategic Prevention Framework Partnerships for Success

The Rhode Island Strategic Prevention Framework Partnerships for Success (SPF-PFS) project enhances efforts to stop underage drinking with youth ages 12-17. Additional priorities are reducing marijuana use among youth 12-17 and assessing prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden of this drug use. There is emphasis on funding sub-recipients in twelve Rhode Island communities of high need, who comprise a large percentage of the state's population.

OHIC

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has led a variety of initiatives to reform the health care delivery and payment system as part of its mission to improve the affordability of health insurance for consumers and employers. OHIC first implemented its Affordability Standards in 2010, focusing on increasing primary care spend, accelerating patient-centered medical home efforts, and reducing the rate of hospital cost increases. In February 2015, after an intensive stakeholder process to solicit recommendations and comments, OHIC updated its Affordability Standards in order to recognize current developments in the health care sector. The revised Affordability Standards focus on practice transformation (including Patient-Centered Medical Home adoption) and driving health care payment practices toward value-based models. OHIC continues to work with its stakeholders and other health care reform efforts in the state. Through these collaborations, which include the SIM project and Reinventing Medicaid, OHIC aims to drive the system toward value, composed of efficiency and quality, inclusive of clinical-best practices, safety, and patient satisfaction.

To assist in this work, OHIC has convened two committees: Care Transformation Advisory Committee and the Alternative Payment Methodology Advisory Committee.

Care Transformation Advisory Committee

This Committee is charged with developing an annual care transformation plan designed to achieve the new Affordability Standards requirement: 80% of the primary care practices contracting with the Health Insurer are to be functioning as Patient-Centered Medical Homes (PCMHs), no later than December 31, 2019. The Care Transformation Committee advises OHIC on the challenges faced by provider, insurer and consumer stakeholders and devises possible responses to these issues. The plan, which includes yearly targets for PCMH adoption and activities to support care transformation, is submitted for the Health Insurance Commissioner's approval each year.

Alternative Payment Methodology Committee

This Committee is charged with developing an annual Alternative Payment Methodology (APM) plan for increasing the use of alternative payment methodologies aimed at driving payment toward value-based models that reward improved quality, efficiency and patient-centric care delivery. The plan, which includes types of payments that qualify as APM payments, annual targets, target dates, and steps payers will take to achieve these targets, is also submitted for the Health Insurance Commissioner's approval annually.

These two Committees significantly contribute to the stakeholder engagement that supports the SIM project. They have been convened twice, once in spring 2015 to develop the 2016 Care

Transformation and APM Plans and once in fall 2015 to develop the 2017 plans. In February 2016, the Commissioner approved the 2017 plans. OHIC anticipates working with committee members to implement the plans throughout 2016 and will reconvene the two Committees in the fall to discuss activities and targets for 2018. OHIC will continue to work with other state agencies as part of the SIM effort to align delivery and payment system reform efforts.

Governor's Office Initiatives

Finally, Governor Gina Raimondo created the Working Group for Healthcare Innovation in 2015, to build on the foundation of our Working Group to Reinvent Medicaid and to improve patient care and health outcomes, and lower costs for all Rhode Islanders. Chaired by Health and Human Services Secretary Elizabeth Roberts, the group developed recommendations to improve the state's healthcare system, support better health outcomes, lower costs and provide businesses with more predictability, including the creation of an Office of Health Policy within EOHHS to better coordinate health policy decisions that affect all Rhode Islanders, and the consideration of a global healthcare spending target. The administration is in the process of determining how to implement the recommendations.

Reinventing Medicaid
In February 2015, Governor Raimondo established the Working Group for Reinventing Medicaid with the duty to review the current Medicaid program and recommend specific quality improvement and cost containment measures for redesigning Medicaid[11]. The group identified many shortcomings of the current program, including misaligned incentives across the delivery system, fragmented and non-coordinated service delivery, and an inability to address social determinants of health, that ultimately result in high costs and less than favorable outcomes. The Working Group's final report includes ten goals based on four principles: 1) Pay for value, not for volume; 2) Coordinate physical, behavioral, and long-term healthcare; 3) Rebalance the delivery system away from high-cost settings; and 4) Promote efficiency, transparency, and flexibility. The report suggests leveraging the role of SIM to define desired population health outcomes as well as a set of aligned measures that can be drawn upon to evaluate the success of the Reinventing Medicaid interventions. In order to achieve the goals set out in the report, the Working Group recommends robust stakeholder engagement and coordination between public and private healthcare reform efforts.

Governor's Working Group for Healthcare Innovation

Finally, building on the successes of Reinventing Medicaid, the Governor's Working Group for Healthcare Innovation was established in July 2015 and charged with making recommendations to establish a global healthcare spending cap, tie payments to quality, create a statewide performance management framework for achieving population health goals, and develop a coordinated health information technology system[12]. With the Triple Aim as the ultimate goal in mind, the Working Group articulated four major recommendations: 1) Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation; 2) Hold the system accountable for cost and quality, and increase transparency through a spending target; 3) Expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs; 4) Align policies around alternative payment models, population health, health information technology, and other priorities. Under the first recommendation, the Working Group calls for the creation of a comprehensive state population health plan, which would be best served by ongoing SIM processes that should combine existing state health planning documents and include details on quality metrics, capacity and needs planning, workforce development, and performance management.

Health Information Technology/Exchange Implementation Advanced Planning Document (HIT/E - IAPD

EOHHS administers the Medicaid EHR incentive program and as part of that program has been successfully receiving 90/10 funding since 2012 to help support the continued development and implementation of Rhode Island's statewide HIE, CurrentCare.

The Rhode Island Quality Institute (RIQI), which serves as the state's regional health information organization/and was designated as the state's HIE entity, implemented a voluntary funding model in 2012 through which all of the major commercial insurers, a number of self-funded employers including state employees, and Medicaid all started contributing $1 per member per month based on the number of covered lives. This funding model has supported activities such as increasing the numbers of providers that can access CurrentCare services (viewer, hospital and ED notifications, receiving CurrentCare Continuity of Care Documents (CCDs), onboarding additional providers as data submitting partners (including practices sending CCDs), enrollment of individuals into CurrentCare, and some of the very early provider directory design work. Through the EHR incentive program's HIE- IAPD initiative, Rhode Island Medicaid has been able to obtain 90/10 funding to support RIQI's multi-payer financing model.

Since CMS has recently expanded HIE initiatives that are considered to be eligible for 90/10 funding, Rhode Island's HIT coordinator and SIM HIT specialist are identifying additional HIE initiatives that may be eligible for the enhanced 90/10 funding. Ideas under consideration are all complementary to SIM's overall objectives and would likely focus on supporting care transitions, community health teams, public health reporting and initiatives and expanding quality measurement efforts or patient engagement strategies beyond SIM's contribution. Some of the ideas under consideration support additional CurrentCare capabilities and some do not, but all of the efforts will be aligned with the SIM HIT work plan and will be synergistic. Additionally, since RIQI currently has two ONC grants – one focused on onboarding and engaging with long term care facilities and the other focused on sharing behavioral health data from the largest adult psychiatric hospital in the state – the state's HIT staff will work with RIQI to identify what additional work is needed that is not currently covered by these grants when scoping additional 90/10 HIE funding requests.

Rhode Island's EHR incentive Program will be submitting both an updated State Medicaid Health Information Technology Plan (SMHP) and an update HIT/HIE IAPD this summer. These HIT initiatives are firmly part of our Integration & Alignment project. We will use the SIM Interagency Team and the HIT governance bodies and staff described in the HIT section to ensure that the SMH plans align with and references the SIM HIT plan, as well as the existing programs described above.

Other State Departments with which SIM will Align

SIM's multi-sector/multi-agency approach applies equally to our system changes and our and population health improvement programs. Throughout this plan, we have described the process of establishing meaningful connections with entities within our healthcare system – and we are also committed to building connections outside of the traditional public health and healthcare delivery systems. Especially as we wrote our Integrated Population Health Plan, we assessed the strategic goals and current initiatives of state departments to identify areas of common focus and opportunities for linkage with population health planning.

As we noted in the Population Health section of the plan, building a community health business model in Rhode Island will require the commitment and cohesive policy making of a wide range of state government actors. Below, we flag some of the key state agencies that we will prioritize with this part of the Integration & Alignment Project.

Rhode Island Department of Education (RIDE)

Rhode Island's Strategic Plan for Education 2015-2020 includes a goal of increasing early childhood developmental screening rates for children aged 3-5 by 15%. This will be achieved in part through promotion of the use of high-quality health and educational screening of young children and the distribution of family-friendly information about early childhood development. There is a clear opportunity for partnership between the healthcare delivery system and department of education; healthcare providers and schools can collaborate to establish protocols for ensuring that all students have access to well child visits and early childhood screening, and that the importance of education to child wellbeing is communicated to parents.
The Strategic Plan for Education also calls for collaborations with public and private behavioral health providers to expand the quality and quantity of in-school behavioral health services. Again, there is an opportunity to develop and leverage mutually beneficial partnerships between schools, state agencies, and healthcare providers to maximize access to behavioral health services in the school setting.

Rhode Island Department of Children, Youth, and Families (DCYF)

In the Rhode Island Title IV-B Child and Family Service Plan, DCYF identifies the priority to reduce reliance on congregate care and increase community-based service supports for children and families through investments in effective wraparound care coordination. This priority aligns with SIM's emphasis on care integration, and offers a dynamic opportunity for partnership between DCYF, healthcare providers, and social service providers to implement a "no wrong door" approach and ensure coordinated access to medical, behavioral health, and social services, particularly among some of our most vulnerable residents.

Rhode Island Department of Corrections (DOC)

The Governor's Working Group for Justice Reinvestment, established in July 2015, is tasked with improving the treatment of mental illness and substance abuse, among other directives. While a formal plan for achieving this task is not yet available, working group materials recommend requiring a behavioral health screening pre-arraignment to identify risks and needs, and to increase access to timely behavioral health services among probationers. This presents a clear opportunity for alignment with SIM's integrated population health, as access to quality behavioral health care is one of the plan's top priorities.

Division of Planning – Housing

In 2012 the Rhode Island Division of Planning, Housing Resources Commission collaborated with Rhode Island Housing and the United Way to develop a strategic plan for ending homelessness, entitled Opening Doors Rhode Island. One of the key goals of this plan is to improve health and housing stability through strengthening access to behavioral healthcare services among vulnerable populations, expanding access to primary care, and leveraging Medicaid funding to finance services in supportive housing. Access to both primary and behavioral health care aligns with the mission of the population health plan, and since permanent supportive housing interventions have been shown to demonstrate significant

reductions in overutilization of medical resources, opportunities for collaboration should be of mutual interest to housing advocates and health reformers.

Division of Planning – Economic Development

Rhode Island Rising, the state's Economic Development Plan released in 2014, identifies an overarching goal of coordinating economic, housing, and transportation investments to yield economic gain, create resilient communities, and improve quality of life. A particular focus is on incorporating pedestrian and bicycle amenities into redevelopment opportunities and promoting alternative transportation to connect people to housing, jobs, and services. Aligning the population health plan with these goals presents a unique opportunity to address environmental and social determinants of health through the development of healthy communities.

The logical next step to building a community health business model would be to reach out to these state departments to establish a common vision, identify interventions, and explore available resources that can be leveraged.

Key Planning Documents Related to Reforming Rhode Island's Health Care System

Besides the initiatives listed above, the state has commissioned several investigations into the current health of populations in Rhode Island, the performance of health reform efforts, and the remaining challenges. While these analyses and reports focus on different aspects of the healthcare delivery system, a recurring theme in the recommendations is the need for coordination and alignment between stakeholders, initiatives, and segments of the delivery system. We have provided a summary of these reports and their respective recommendations to add to the picture of our health reform landscape.

Healthcare Utilization and Capacity Study

In late 2015 RIDOH, in consultation with the Health Care Planning and Accountability Advisory Council (HCPAAC), conducted a statewide healthcare utilization and capacity study as required by the Rhode Island Access to Medical Technology Innovation Act of 2014 (RI Gen. Laws § 23-93-5(b))[13]. The study collected data on the location, distribution, and nature of healthcare resources in healthcare settings across the state. Detailed surveys were completed by providers in primary care settings, outpatient specialty practices, behavioral health settings, hospitals, nursing facilities, assisted living residences, adult day care programs, home health settings, MRI imaging centers, ambulatory surgery centers, and dialysis centers.

A patient and community survey was also administered. A study of this magnitude had not been completed in Rhode Island since the 1980's. Results indicated an overall shortage of primary care providers, limited data on patient race, ethnicity, and primary language and lack of interpreter services, limited availability of assisted living residencies for Medicaid patients, and persisting financial barriers to care. RIDOH recommends exploring strategies for recruitment and retention of primary care providers, implementing uniform data collection of demographic information and identification of cost barriers, and improving access to community-based care. Data collection and analysis will be repeated annually, and the data collected will be used to establish and maintain a statewide health plan; similar to the Governor's working groups, the report suggests drawing on the work of SIM in the creation of a population health plan.

Truven Report

Around the same time, Truven Health Analytics was contracted by EOHHS, BHDDH, RIDOH and OHIC to conduct detailed analyses and develop a report evaluating current statewide demand, spending, and supply for the full continuum of behavioral health services in Rhode Island[14]. The analysis, published in September 2015, applied a population health approach by organizing population groups and evaluating need, prevention, and treatment services by lifespan stage. Key findings indicated that children in Rhode Island face higher risks for developing mental health and substance use disorders compared to other New England states, Rhode Island spends more on behavioral health than other states, and reporting and service delivery systems are fragmented. The report articulates three recommendations: 1) place greater investment in efficacious preventive services for children and families, 2) shift financing from high cost, intensive, and reactive services to evidence based services that promote patient-centered, outcome focused, coordinated care, 3) enhance infrastructure to promote population health based approach to behavioral healthcare.

Health Disparities Report

The Rhode Island Commission for Health Advocacy and Equity, a group established by statute in 2011 (RI Gen. Laws §23-64.1) and supported by RIDOH, submitted a report to the General Assembly in January 2015, detailing a study of health disparities in six key health areas: maternal and child health, asthma, obesity, diabetes, heart disease, and oral health[15]. The report focused heavily on the social determinants of health and disparities between groups of Rhode Islanders with regard to educational attainment, disability status, race and ethnicity, and income. In addition to specific health topic area recommendations, the report gives global recommendations for improving health equity. These include: adopting a health in all policies approach, improving systems for collecting health disparities data, strengthening Rhode Island's capacity to address health inequities, expanding partnerships, and coordinating efforts for action.

Rhode Island's Strategic Plan for Addiction and Overdose

The opiate epidemic, and increase in related deaths due to overdose, in Rhode Island spurred Governor Raimondo to issue Executive Order 15-14. The Order established creation of a broadly representative Task Force charged with developing a strategic plan for impacting opiate use disorders in Rhode Island. Co-chaired by the Directors of the BHDDH and RIDOH, the Task Force sought expert advisors who reviewed the existing literature on addiction and overdose; conducted over 50 interviews with local, national, and international stakeholders and experts; collected input from the Rhode Island community; and hosted two public forums with expert and community panels. These efforts culminated in "Rhode Island's Strategic Plan for Addiction and Overdose," which established the long-term goal of reducing overdose related deaths by one-third within the next three years. The Task Force issued a report of recommendations intended to move Rhode Island forward in meeting this goal, including: a "no-wrong door approach to accessing medication assisted treatment; increasing access to evidence-based treatment and recovery supports for opiate abuse/dependence; requiring training for physicians and law enforcement personnel; reducing administrative barriers that limit access to opioid use disorder treatment; and requiring data collection and reporting on measure that will assess the impact of the proposed interventions.[92]

[92] Rhode Island's Strategic Plan on Addiction and Overdose, 2015

Additional Community Research

In addition to the reports mentioned above, there are a number of community nonprofits or research entities that create health-related reports that are very helpful to the SIM project. These organizations include Kids Count (whose Executive Director is on the SIM Steering Committee), the Economic Progress Institute; the Rhode Island Public Expenditure Council (RIPEC), Rhode Island Medical Society (whose Director of Government and Public Affairs is a member of the Integrated Population Health Workgroup), and the Rhode Island Business Group on Health (whose Executive Director is also on the SIM Steering Committee).

Workforce Capacity Monitoring

Stakeholder Engagement

Fundamental to restructuring the healthcare delivery system and achieving the Triple Aim is the development and support of a workforce that has the training, knowledge, and experience necessary to deliver healthcare and wellness services in new and innovative ways. This is likely to entail new job titles, new duties, new work settings, and new skill sets for healthcare employees. This "workforce transformation" cannot and will not be achieved by a single healthcare provider, educational institution, or payer. Rather, it will take an unprecedented collaborative and visionary approach by all stakeholders to identify and implement new workforce development strategies that will successfully address the current and projected workforce needs of healthcare providers and the community at-large. Please note: When we use the term healthcare workforce, we are thinking of it broadly, to include not just clinic staff, but HIT and Data managers, first responders, public health and community health staff, laboratory scientists, auxiliary staff within our healthcare facilities, etc. The SIM project may not affect all of those staffing areas, but we conceive of the concept expansively.

The Rhode Island Executive Office of Health & Human Services has recently demonstrated its commitment to aligning healthcare workforce development and delivery system transformation by creating the position of Director of Healthcare Workforce Transformation, which will be responsible for developing and overseeing the implementation of a healthcare workforce transformation plan for the state. This workforce planning process will engage a multi-stakeholder Healthcare Workforce Transformation Workgroup (HWTG) comprised of key stakeholders representing healthcare providers, primary care organizations, educators (K-12 and post-secondary), professional associations, Rhode Island chapters of national organizations, labor organizations, managed care organizations, and appropriate state agencies. The HWTG will advise the workforce planning process and develop strategies that support the SIM project, as well as Rhode Island's Medicaid-led Health System Transformation Program. Specifically, the HWTG will:

- Develop a profile of the current healthcare workforce in Rhode Island, including job titles, duties, employment levels, education requirements, skill requirements, licensure requirements, etc.
- Determine the type of continuing education and training needed by the current workforce, consistent with anticipated healthcare delivery system restructuring
- Develop a profile of the future healthcare workforce in Rhode Island, consistent with anticipated healthcare delivery system restructuring
- Determine the type of training and education needed to prepare the future workforce, consistent with anticipated healthcare delivery system restructuring
- Determine the capacity of healthcare providers and education and training institutions to meet the education and training needs of the current and future workforce
- Identify barriers to achieving workforce transformation, and strategies to overcome such barriers, including: labor market competition among healthcare providers; divergent patient care models and skill mixes among healthcare providers; lack of coordination and/or consensus among education and training providers; resistance from employees, professional association, and unions; workforce skills gaps; limited training and education capacity; prohibitive training costs, etc.
- Develop workforce transformation metrics

The HWTG will also provide a structure for stakeholders to exchange information about healthcare workforce trends and ensure that all partners are aware of industry needs and opportunities. The HWTG will also work to ensure that all healthcare workforce training resources are used to build strong partners between healthcare educators and providers that are responsive to the workforce needs and healthcare system transformation goals identified in the healthcare workforce transformation plan.

We will develop workforce outcome targets over the next six months. They will be based upon a detailed assessment of the current healthcare workforce "supply" (i.e., occupations, settings, education, demographics, etc.) and the current and projected healthcare workforce "demand" (i.e., current and projected vacancies, occupations, settings, education, etc.). The assessment will also include an analysis of the current healthcare workforce education and training capacity (i.e., types of programs, number of graduates, etc.) This assessment will be thoroughly reviewed by the SIM HWTG and SIM Steering Committee, and will result in the development of a healthcare workforce transformation plan that is focused on the state's population health and delivery system transformation goals. Outcome targets will be developed and refined through an iterative and collaborative process that will engage healthcare educators and providers in designing, implementing, evaluating, and revising innovative healthcare workforce development initiatives.

Research and Studies

A number of on-going and ad hoc efforts have been undertaken in Rhode Island to document current healthcare workforce supply and demand, as well as current and projected employment levels, by occupation and sectors of the healthcare industry.

Department of Labor & Training Labor Market Information

The Labor Market Information (LMI) division of the Rhode Island Department of Labor & Training collects and reports a wealth of labor market data on a regular or as-needed basis. This data – which is derived from census data, wage records, and employer surveys -- is often further analyzed, customized, and cited by educators, healthcare providers, policy-makers, and others to assist in planning efforts. Some examples of useful LMI data include:

For every healthcare occupation

- Total employed
- Projected employment over 10 years
- Projected growth rate over 10 years
- Projected vacancy rate (growth plus attrition)
- Age of workforce
- Wage rates (average minimum, mean, maximum)
- Unemployment rates and numbers
- Current job postings
- Educational requirements
- Comparisons with same occupations in other states

For all healthcare employers

- Number of employers by sector (eg, hospital, long-term care, ambulatory)
- Total employment by sector
- Age of workforce by sector

- Wage rates by sector

Tables 18-20 show some data we have to answer some of these questions. Additional data will be collected and reviewed to further our SIM work.

Table 18: Employment in the Health Care and Social Assistance Sector

	Health Care and Social Assistance Sector	Healthcare Practitioners & Technical	Healthcare Support	Personal Care & Service
2012 Annual Employment	80,648	*36,275*	*19,971*	*18,846*
2022 Projected Employment	94,500	*40,886*	*24,044*	*22,271*
Numeric Change	13,852	*4,611*	*4,073*	*3,425*
Percent Change	17.20%	*12.70%*	*20.40%*	*18.20%*
Openings due to	**Growth**	*4,662*	*4,087*	*3,436*
	Replacements	*7,456*	*3,793*	*3,850*
	Total	*12,118*	*7,880*	*7,286*

Table 19: Projected Number of Job Openings (Growth + Replacements)

Profession	Job Openings
Registered Nurses	4,125
Nursing Assistants	3,883
Home Health Aides	1,995
Personal Care Aides	1,935
Social & Human Service Assistants	1097
Medical Secretaries	1047
Physical Therapists	611
Medical & Health Services Managers	595
Licensed Practical & Licensed Vocational Nurses	545
Substance Abuse & Behavioral Disorder Counselors	363
Pharmacy Technicians	291
Medical and Clinical Laboratory Technicians	280
Healthcare Social Workers	206
Mental Health Counselors	189
Occupational Therapists	174

Table 20: Occupations with the Most Job Postings per Unemployment Insurance Claimant

Occupational Title	Current Job Postings	Claimants	Postings per claimant	Educational requirement
Nurse Practitioners	176	1	176	Master's
Physical Therapists	256	2	128	Doctoral/Professional
Clinical, Counseling, & School Psychologists	48	1	48	Doctoral/Professional
Pharmacists	84	2	42	Doctoral/Professional
Phlebotomists	39	1	39	Postsecondary
Physician Assistants	34	1	34	Master's
Registered Nurses	1,494	48	31.1	Associate
Occupational Therapists	42	2	21	Master's
Dietetic Technicians	18	1	18	High School/GED
Physical Therapist Assistants	51	3	17	Associate
Licensed Practical Nurses	147	9	16.3	Postsecondary

According to the most recent LMI data shown below in Table 13, Rhode Island's Healthcare and Social Assistance sector employed 81,413 people in the third quarter of 2015, representing nearly 20% of the state's entire private sector workforce. Of these, 18,414 were employed in nursing and residential care facilities, 23,675 in hospitals, 26,544 in ambulatory healthcare services, and 12,780 in social assistance. Furthermore, the Healthcare and Social Assistance sector is comprised of 3,332 distinct employers. 85% of these entities employ fewer than 20 workers; while 25% of the healthcare and social assistance workforce is employed by just 53 employers. We will continue to seek out additional healthcare workforce data, including actual and forecasted hires, attrition related to retirement and non-retirement, including the number of incumbent workers who are at or over retirement ago.

The state does not currently collect data on hours worked in patient care by healthcare professionals; however, the RI Department of Health is exploring the possibility of collecting this information as part of the health professional licensure renewal process.

Table 21: Rhode Island's Healthcare and Social Assistance Sector Workforce

Healthcare & Social Assistance	Total	0-19	20-49	50-99	100-249	250-999	1000+
Ambulatory Healthcare Services							
# of Firms	1,830	1,608	123	48	32	19	-
# of Employees	26,544	7,765	3,693	3,389	4,487	7,210	-
Hospitals							
# of Firms	21	•	•	•	•	6	8
# of Employees	23,675	•	•	•	•	4,762	18,657
Nursing and Residential Care Facilities							
# of Firms	175	90	29	40	64	12	-
# of Employees	18,414	160	930	2,836	9,601	4,887	-
Social Assistance							
# of Firms	1,306	1,194	65	28	11	8	-
# of Employees	12,780	3,655	1,981	1,919	1,713	3,512	-

Total							
Total # of Firms	3,332						
Total # of Employees	81,413						
Note: Some Hospital data has been omitted in order to preserve the confidentiality of individual entities. *Source: RI DLT, September 2015 QCEW* *Column headings represent the size of firm, based on number of employees*							

Workforce Intermediaries

For the past ten years, the Governor's Workforce Board of Rhode Island has supported "Industry Partnerships" to raise awareness of the workforce needs of employers in vital sectors of the Rhode Island economy. In the past year, these Industry Partnerships have been designated as "Real Jobs Rhode Island Partnerships" under a new program run by the Department of Labor & Training. Real Jobs partnerships will continue to serve as workforce intermediaries by providing essential information about the workforce needs, challenges, and opportunities in their industry, so that providers of workforce education, training, and other pre-employment services are well-positioned to respond to employer demand.

In 2014, Rhode Island's healthcare industry partners published a skills gap study entitled, *Rhode Island's Healthcare Workforce: Assessing the skills gap and providing recommendations to meet the industry needs*. The study provides a detailed profile of our current and projected healthcare workforce supply and demand, identifies workforce skills gaps and other workforce challenges, and offers recommendations to address the education and training needs of healthcare employers and workers.

Among the key recommendations in the report were to:

- Develop and expand experiential learning opportunities (i.e., internships, clinical placements, residency programs, etc.)
- Develop career pathways that provide coaching, support, continuing education, and career advancement at all steps on the career ladder
- Incorporate "soft skills" training (i.e., communication, problem-solving, teamwork, cultural competency, etc.) in all workforce training
- Formalize and strengthen partnerships between healthcare providers and educators

Department of Health

In 2015, the Rhode Island Department of Health (RIDOH) published its first biennial Statewide Health Inventory of "all healthcare facilities, health services, and institutional health services", with data on the location, distribution, and nature of the state's healthcare resources, in accordance with Rhode Island law. The law also requires RIDOH to conduct a statewide healthcare utilization and capacity study, and to create a statewide health plan that incorporates the data and analysis of the Statewide Health Inventory to develop the state's Integrated Population Health Plan. While the Statewide Health Inventory does not evaluate the current capacity or need for specific healthcare occupations, it does provide a highly detailed assessment of the range of healthcare services and resources in Rhode Island, and offers several key findings that have implications for workforce development, including:

- The number of full-time equivalents of primary care physicians is up to 40% lower than previous estimates and is about 10% less than national standards for adequate access to care.
- Substantially limited data exists across practices and facilities regarding the race, ethnicity and primary languages of patients, and there is a lack of appropriate interpreter services at many healthcare facilities and practices.

- As the Reinventing Medicaid initiative seeks to expand access to community-based settings for long-term care, 51% of assisted living residences reported they are not accepting new Medicaid patients.
- The survey of patients and communities in Rhode Island suggests that financial barriers, such as high co-pays and deductibles, may be preventing Rhode Island residents from receiving the care they need when they get sick.

In the coming year, RIDOH intends to expand upon the Statewide Health Inventory by conducting surveys of Rhode Island's licensed healthcare professionals (including and expansion to oral health providers) to assess their education, years of service demographics, employment status, and other characteristics that determine the capacity of our healthcare workforce.

Private studies

In addition to the public reports and analyses that will guide SIM workforce strategies, workforce studies and plans are periodically conducted by health systems, colleges and universities, trade associations, professional associations, and public agencies. These reports will also help to inform the work of the SIM project. In addition, SIM may elect to conduct additional labor market research, as warranted, in order to fully assess the workforce needs of our healthcare providers and communities.

Specific SIM-Related Workforce Issues

The SIM project has identified several priorities for healthcare workforce and practice transformation. The following provides a brief overview of the challenges and opportunities for each.

Behavioral Health/Substance Abuse

As noted elsewhere, Rhode Island faces substantial healthcare, workforce, and cost-related challenges in responding to the substantial behavioral health needs in Rhode Island, including substance abuse, trauma, Alzheimer's and dementia, and developmental disabilities. The increasing demand for services, an aging workforce, and high employee turnover rates have all contributed to a growing behavioral health labor shortage. Solutions to this shortage will require an increased focus on developing behavioral healthcare career pathways, as well as on new care delivery models, both of which will require innovative approaches to preparing the behavioral healthcare workforce.

Community Health Workers

Like many states, Rhode Island is actively exploring the use and potential of Community Health Workers in supporting patients and caregivers as integral members of Community Health Teams. The Rhode Island College Community Health and Wellness Program has partnered with healthcare providers and policy-makers to identify the need and opportunities for training, and perhaps certifying, Community Health Workers. Currently, there is little consensus regarding the scope of practice, training and education, certification, or compensation of Community Health Workers in Rhode Island. Within the category of CHWs, there are two types: generalists (such as patient navigators for physical or behavioral health) and specialists (such as an Advanced Lactation Consultant, Certified Peer Recovery Specialist, or Diabetes Prevention Coach that require additional certification). Exploration of other collaborations continue, such as the inclusion of RI 2-1-1 or HealthSourceRI resource specialists under this umbrella. Additional collaboration may include integration within community paramedicine and public health dental hygienist models here in RI.

The SIM project recognizes the importance of clarifying these issues pertaining to Community Health Workers as this workforce resource becomes professionalized through the Rhode Island Certification Board, starting in May 2016. Professionalizing this workforce resource within Rhode Island's employment marketplace and across the state's institutions may lend additional credibility to the field and access to a new pipeline of public servants and service leaders. Doing this in coordination with CHT investments will better address the social and environmental factors that significantly contribute to the health outcomes of a population. Such new investments will aid in long-term sustainability discussions with insurers of all types on the benefits of covering new services.

To bring the CHW across the integrated physical and behavioral health continuum of care, existing staff functioning as CHWs can apply for certification via a grandparenting mechanism through November 2017. After that, those who seek certification credentials will need to take and exam in addition to meeting the requirements. For application information, visit: http://www.ricertboard.org/uploads/2/4/5/3/24535823/ricb_cchwgrandparentingapplication.pdf.

Information Technology
Under the leadership of Governor Gina M. Raimondo, Rhode Island has launched several new initiatives to increase the information technology skills of the state's workforce. Among these new initiatives are P-Tech (a dual enrollment program that enables high school students to access college-level courses and internships in IT occupations); TechHire (a competency-based IT training program for unemployed and underemployed Rhode Islanders); and CS4RI (a high school-based computer science initiative). In addition, YearUp-Providence, a one-year, intensive training program for low-income young adults, has launched a partnership with Lifespan, Rhode Island's largest hospital system, to provide hands-on skill development, college credits, and corporate internships in healthcare information technology. These IT programs can and will be leveraged by SIM to increase the health IT capacity of the healthcare workforce.

Health Professional Education
Integral to the SIM Workforce and Practice Transformation model will be the need to prepare Registered Nurses and other health professionals for working in interdisciplinary teams and in specialties such as home care, behavioral health, chronic care management, community health, health informatics, and other areas of focus in the SIM project. To accomplish this specialized training, it will be essential for healthcare providers and educators to join forces to provide expanded and focused clinical and didactic training both pre- and post-licensure. The SIM project will convene and support providers and educators to develop innovative approaches to health professional education. To aid in this effort, partnership with the RIDOH Academic Center, focused on workforce development for public health through formal communication and collaboration with academic institutions and other community resources can be further developed to include needs of the entire health system. For more information on the Academic Center, see the "Alignment with State and Federal Initiatives" section.

Legislative, Regulatory or Executive Actions

Licensure and Scope of Practice issues
As the SIM project embarks on workforce and practice transformation, it is likely that consideration and development of new or expanded healthcare worker roles will raise challenging issues regarding scope of practice and licensure. SIM can provide a table at which such issues can be thoughtfully addressed, in collaboration with educators, providers, professional associations, labor organizations, and policy-makers, in order to develop a

consensus around the definitions, certification, and/or licensure requirements necessary to achieve an efficient and effective healthcare workforce.

Budgetary issues
The SIM recognizes that workforce and practice transformation inevitably raises questions and challenges related to employee compensation, working conditions, and retention. This is particularly true of entry-level workers such as home health aides, peer recovery specialists, direct support workers for individuals with developmental disabilities, community health workers, and Certified Nurses' Aides. While such issues cannot be addressed by funding alone, the desire to create a stable and skilled workforce may have budgetary implications.

Tuition and/or loan forgiveness for health professional graduates who remain in Rhode Island and practice in priority settings is another potential workforce strategy that might require legislative and/or executive branch action.

Provider incentives to support workforce development
As Rhode Island further develops provider incentives to transform the healthcare delivery system, opportunities may also exist to enlist and align providers in achieving healthcare workforce development objectives. For example, community-based healthcare providers might be offered incentive payments for providing internship opportunities, clinical placements, and/or employment opportunities to students and/or recent graduates. Such incentives would likely require regulatory action.

Health Workforce Capacity Programs

Healthcare education and training capacity
Much like Rhode Island's healthcare delivery system, Rhode Island's healthcare education and training providers are numerous, varied, and, in some cases, siloed and/or duplicative. At Rhode Island's three public institutions of higher education alone, there are more than 100 distinct healthcare education degree and certificate programs. In addition, four private colleges and universities in the state offer more than 20 other healthcare degree programs. Rhode Island also has one medical school, the Albert Medical School at Brown University, which has seven affiliated teaching hospitals and awards approximately 100 MD degrees each year.

Scores of non-credit healthcare workforce training programs are also offered by colleges, high schools, community-based organizations, and proprietary training providers in Rhode Island. These programs often serve low-income, unemployed, and underemployed adults, and are typically supported by public workforce development funds.

The extent to which the "output" of these many degree-granting and not-for-credit programs meets or exceeds current and projected labor market demand in Rhode Island's healthcare sector has yet to be assessed, and will be a major focus of SIM research. SIM also recognizes that workforce transformation efforts must be guided not simply by an assessment of the number of healthcare workers that will be needed, but rather by an assessment of the skills and competencies that will be needed. As an illustration, there is increasing recognition that peer support and counseling are effective interventions to augment traditional clinical treatment for persons with behavioral health issues. Rhode Island's BHDDH continues to build a skilled workforce of peer specialists (i.e., persons with self-identified mental health and/or substance use conditions), by offering a specialized training and certification program as well as employment opportunities with local providers.

Finally, SIM recognizes that for healthcare workforce transformation efforts to have a significant impact, RI education and training providers must focus their efforts not simply on the education of newly graduating healthcare workers, but rather on providing continuing education and training for the *current* healthcare workforce, in partnership with healthcare provider organizations.

An example of how Rhode Island is helping one segment of the current healthcare workforce to learn new competencies is the SIM funded Provider Coaching Project. Over a three year period, staff of Rhode Island's eight Community Mental Health Centers will receive training and consultative service to help them become more skilled in managing the health care needs of adults with serious mental illness. Through the provider coaching program, staff will learn to better assess, treat and track consumers' physical health conditions in collaboration with primary care physicians, with the major goal to show improvements in consumers' health behaviors (e.g., diet, exercise, tobacco use) and status (e.g., reduced rates of obesity).

In addition, thanks to the SBIRT grant we have just received from SAMHSA (described on Page 50) will allow us to assist primary care and Emergency Department providers in learning to conduct substance use screenings.

Federal Healthcare Workforce Resources

The bulk of federal funding for health care workforce comes from CMS and goes to Graduate Medical Education (GMEs) for training physicians through residency programs at hospitals and other entities. However, there are other programs funded by the federal DHHS for training physicians such as grants to Teaching Health Centers. There are also grants for specific residencies such as at children's hospitals and autism training. HHS also provides funding to address geographic shortages and shortages in medically underserved areas, including primary medical, mental and dental care providers as well as NHSC loans and scholarships, the Area Health Education Centers and any Indian Health Service programs directed at workforce. There are workforce diversity programs which include grants for Centers of Excellence, scholarships for minorities and a Minority Fellowship Program. There are also miscellaneous programs such as health professions student loans, Geriatric Education Centers (there is one at the University of RI), AIDS education and Training Centers and Community-based Dental Partnerships.

Workforce planning by healthcare educators and providers

In 2015, Rhode Island's healthcare Industry Partnership, in collaboration with the Governor's Workforce Board and the Office of the Post-Secondary Commissioner, convened a half-day meeting of more than 50 healthcare employers and college-level educators to review Rhode Island labor market and college graduation data in order to determine 1) whether the DLT's 10-year labor market projections were corroborated by the providers and educators; 2) whether the healthcare education programs have the capacity to meet the current and projected labor market demand for college-prepared health professionals; and 3) if not, what could be done to adapt or expand current capacity to meet future demand.

Among the key takeaways from the meeting were 1) the need for new strategies to prepare newly graduated RNs to work in specialty areas; 2) the growing need for behavioral health occupations such as Licensed Chemical Dependency Specialist; and 3) and the importance of cultural competence and soft skills (e.g., communication, teamwork, problem-solving).

Rhode Island's Commissioner of Post-Secondary Education remains engaged and committed to increasing the alignment and capacity of the state's higher education institutions with the in-demand occupations in Rhode Island's healthcare industry. Similarly, the Rhode Island

Department of Labor & Training is committed to supporting workforce development initiatives that respond to employer demand in the healthcare sector, and the Rhode Island Department of Education is committed to developing career pathways for high school students, as well as adult learners, that align with the workforce needs and opportunities in Rhode Island's key industry sectors, such as healthcare.

There is a broad cross section of workforce development partners in Rhode Island that stand ready to respond to the workforce needs of Rhode Island's evolving healthcare delivery system. The SIM project will convene these agencies as new partners in our work so that together with healthcare industry representatives, we can help build the healthcare workforce of the future.

Health Information Technology

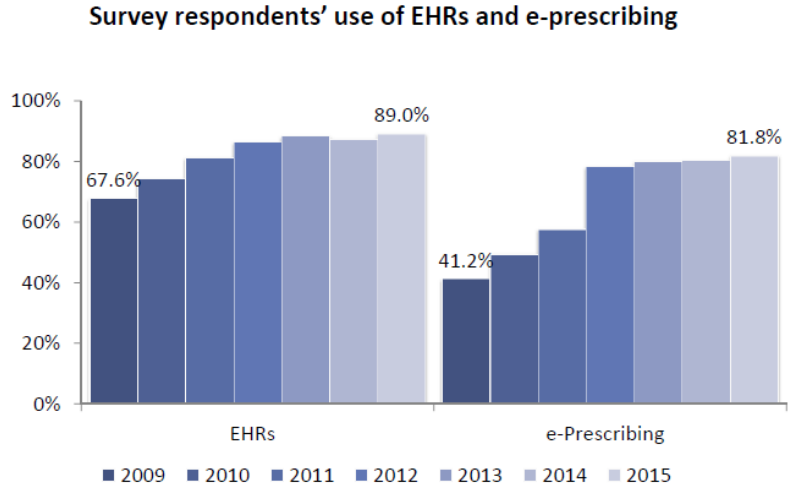
Health Information Technology (HIT) projects are foundational elements in our plan for Rhode Island's health system transformation. Rhode Island has been and continues to be a leader in statewide HIT investments. Starting in 1997, the Rhode Island Department of Health (RIDOH) implemented KIDSNET, an integrated child health information system, which has served as a pediatric health information exchange for public health programs and pediatric providers. In 2004 Rhode Island initiated efforts to build a statewide health information exchange (HIE). In 2009, the state began to monitor Electronic Health Records (EHRs) and e-prescribing adoption rates, and in 2011 efforts to design and build an all payer claims database (APCD) were underway. Rhode Island has also been developing a single platform (RI Bridges, formerly known as UHIP) which integrates and tracks eligibility determination for HealthSource RI, Medicaid and other human services programs. As evidenced by the above, Rhode Island considers HIT a cornerstone of our strategy to increase Rhode Island's healthcare quality – and to implement our strategic Integration & Alignment Project. We can build on the strong relationships that exist between programs and use technology to make these links actionable.

HIT Adoption and Use

Over the past few years, Rhode Island healthcare providers have made great strides in HIT adoption and use. RIDOH has conducted an annual HIT Survey since 2009, and completed its first statewide healthcare inventory in 2015. The HIT survey measures adoption by physicians, while the inventory measures adoption by facility and location.

The 2015 HIT Survey had a 66% response rate and found that of responding physicians, 89.0% had an EHR and 81.8% were e-prescribing. Figure 4 shows the EHR and e-prescribing rates as reported in the HIT Survey for Rhode Island physicians from 2009-2015.

Figure 48: HIT Survey Results, Use of EHRs and E-Prescribing, 2009-2015



In addition to the physician HIT survey, and as a roadmap for how Rhode Island can improve HIT adoption rates, it is also useful to look at EHR adoption rates by practice type or location. Rhode Island's EHR adoption across hospitals is 92.3%, across outpatient specialty locations is 72.7%, and across primary care locations is 82.6%. It is clear that while Rhode Island's average EHR adoption rate across all locations is 77.2%, which is close to the national average of 78%,

efforts to increase EHR adoption need to be focused on specialists and behavioral health facilities or providers. Table 14 shows EHR adoption rates by location type, illustrating the gaps in EHR adoption rates.

Table 22: EHR Adoption Rates, Statewide Healthcare Inventory, 2015

Survey	Total Locations	Response Rate	EHR Adoption Rate
Hospital	13	100%	92.3%
Nursing Facility	89	100%	80.9%
Outpatient Specialty	418	60%	72.7%
Primary Care	311	94.5%	82.6%
Behavioral Health	48	79.2%	39.6%
Psychologists	108	88.9%	33.3%
Psychiatrists	49	100%	24.5%

Notes: Not all respondents answered the EHR adoption questions; there is possible overlap between the outpatient specialty and psychologists survey results; and some outpatient specialty practices are co-located with hospitals.

Rhode Island community organizations have leveraged numerous federal funding opportunities to help increase HIT adoption. In 2010, the Rhode Island Quality Institute (RIQI) received Office of the National Coordinator for Health Information Technology (ONC) funding to serve as a regional extension center, was designated by the state to serve as the state's designated HIE entity to continue to build out CurrentCare (the state's HIE), and was awarded a Beacon grant to focus on how HIT adoption could drive improvements in health care. While all of these grants have ended, RIQI continues to build out and operate CurrentCare and has also recently received additional ONC HIE grants focusing on long term care and behavioral health connectivity to CurrentCare. Additionally, RIQI received a Transforming Clinical Practice Initiative grant (TCPI) to assist providers (primarily specialists) with practice transformation (including EHR and HIE adoption) in preparation for value based purchasing models. SIM works closely with RIQI in all aspects of HIT, and is specifically coordinating work with their TCPI project.

EOHHS administers the Medicaid EHR Incentive program. As part of this program, EOHHS funds RIQI to provide additional technical assistance to Medicaid providers who are struggling to meet Meaningful Use. Lastly, Healthcentric Advisors, a Rhode Island-based nonprofit serves as the as the regional Quality Improvement Organization (QIO), supporting practice transformation and HIT adoption. They also contract with RIDOH to conduct the annual HIT Physician Survey as part of a larger health care public reporting program primarily focused on Long-Term and Post-Acute Care facilities (LTPAC) and hospitals.

State HIT Governance

Rhode Island has a history of HIT governance that relies on working collaboratively across both state agencies as well as with external partners. Given the success of this approach and the notion that many of the HIT initiatives provide the tools and infrastructure upon which various departments rely, no single state agency has the responsibility for overseeing all of the HIT initiatives within state government. Rather the state has adopted an interagency team approach to managing a number of specific HIT initiatives such as the APCD, the Statewide Provider Directory, and RI Bridges (Rhode Island's integrated Health and Human Services eligibility and insurance exchange platform).

The EOHHS and affiliated state agency principals (Cabinet Directors) work together along with staff from the Governor's office to provide strategic direction on HIT initiatives. Principals meetings are held periodically – and their staff members who population the various interagency teams keep the principals well informed on the current status, discuss any existing barriers and challenges, problem solve as needed, and continue to strategically align across HIT initiatives as appropriate.

While much of the work is accomplished in interagency teams, there are also designated agency staff responsible for managing the various HIT initiatives. The EOHHS Director of Analytics provides critical leadership and support to a number of HIT initiatives internal to EOHHS and its agencies such as the RI Bridges project, the Medicaid Management Information Systems, and the current EOHHS data warehouse. The Director of Analytics also serves on the APCD interagency team and importantly, will oversee the SIM state data ecosystem effort.

The State HIT Coordinator is also located within EOHHS and is responsible for managing the state's oversight of Rhode Island's state designated entity for HIE, assuring that our statewide HIE meets the state's needs, serving as a liaison and helping to align statewide HIT efforts across and within Rhode Island, and overseeing the state's Medicaid EHR Incentive Program and its program manager. She also oversees the state's SIM HIT work plan, and serves on additional community-facing HIT projects, such as the APCD interagency team and the provider directory oversight group.

Additionally EOHHS has hired an HIT Specialist who reports to the State HIT Coordinator to specifically drive the development and implementation of the SIM HIT plan.

Finally, there is a Public Health Informatics Manager position (currently vacation) located at the RIDOH. This staff person is responsible for coordinating the work among the public health HIT systems (such as the PDMP, KIDSNET, syndromic surveillance, medical licensure and the statewide HIE), serving as the public health meaningful use coordinator, and serving on the APCD and provider directory interagency teams.

It is also important to note that the state has a centralized Department of IT located within the Department of Administration which handles all technical facilitation centrally for the state. Any IT staff located within an agency are typically part of this centralized IT department but physically located at the agency for which they perform their duties. Additionally the State CIO/Chief Digital Excellence Officer and his staff work closely with each agency within state government as well as with the state interagency teams on HIT projects that are housed within state government. They also consult on all HIT related procurements to assure state IT standards are adhered to.

As stated above, SIM places great value and emphasis on engaging the community and working collaboratively with external partners in developing overall HIT strategy for the state. This partnership and the requisite community input is provided through different mechanisms. Governance of the statewide HIE is primarily through the state designated entity: the Rhode Island Quality institute's (RIQI) Board of Directors as well as their community based committees. The state is well-aligned with RIQI, as the Health Insurance Commissioner and Secretary of EOHHS serve as ex-officio, non-voting members on the RIQI board and the State HIT Coordinator serves on all of RIQI's community based committees. There is also a statutory HIE Advisory Commission that is responsible for advising the Director of Health on the uses of HIE data as well as a statutory APCD Data Release Review Board that provides similar advice to the Director of Health for the APCD. In addition, through RIQI, the Provider Directory Advisory

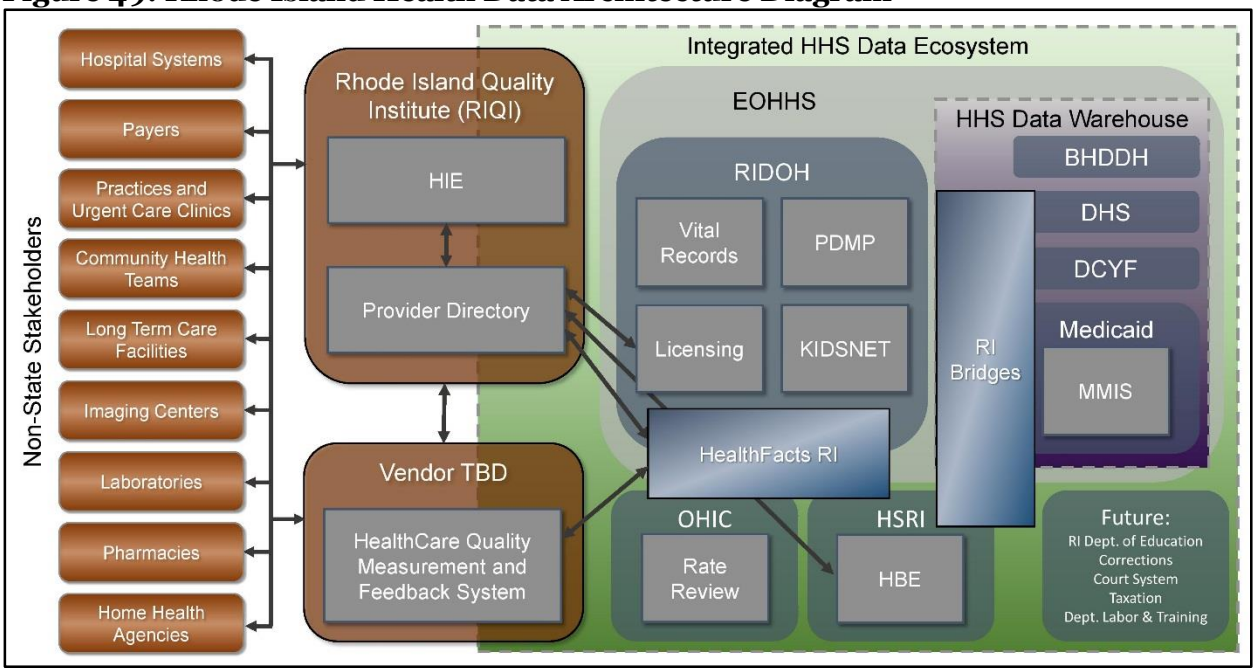
Committee which was originally convened only with representatives of state agencies and RIQI is now expanding to include providers, payers and consumers. Lastly, the Healthcare Quality Measurement Reporting and Feedback System being developed through SIM is being governed by a workgroup of the SIM Steering Committee.

Clearly, there is no central single state agency responsible for all components of the state's HIT efforts. Ghat said, there is unprecedented collaboration that is occurring across state government and with the community to strategically align, leverage, and coordinate HIT activities across the state in support of our Triple Aim goals in Rhode Island.

Existing State HIT Systems

Rhode Island's investments in HIT include a diverse group of systems that help reduce administrative waste, increase EHR adoption, support interoperability, and improve care coordination. The Data Architecture Diagram describes the relationships between these systems and they are described in further detail below.

Figure 49: Rhode Island Health Data Architecture Diagram



RI Bridges

RI Bridges (formerly known as Unified Health Infrastructure Project, UHIP) is designed to be a single technical platform that supports Medicaid and other state human service eligibility, collecting consumer information in a centralized resource. RI Bridges is an interagency initiative between HealthSource RI, the Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC).

KIDSNET

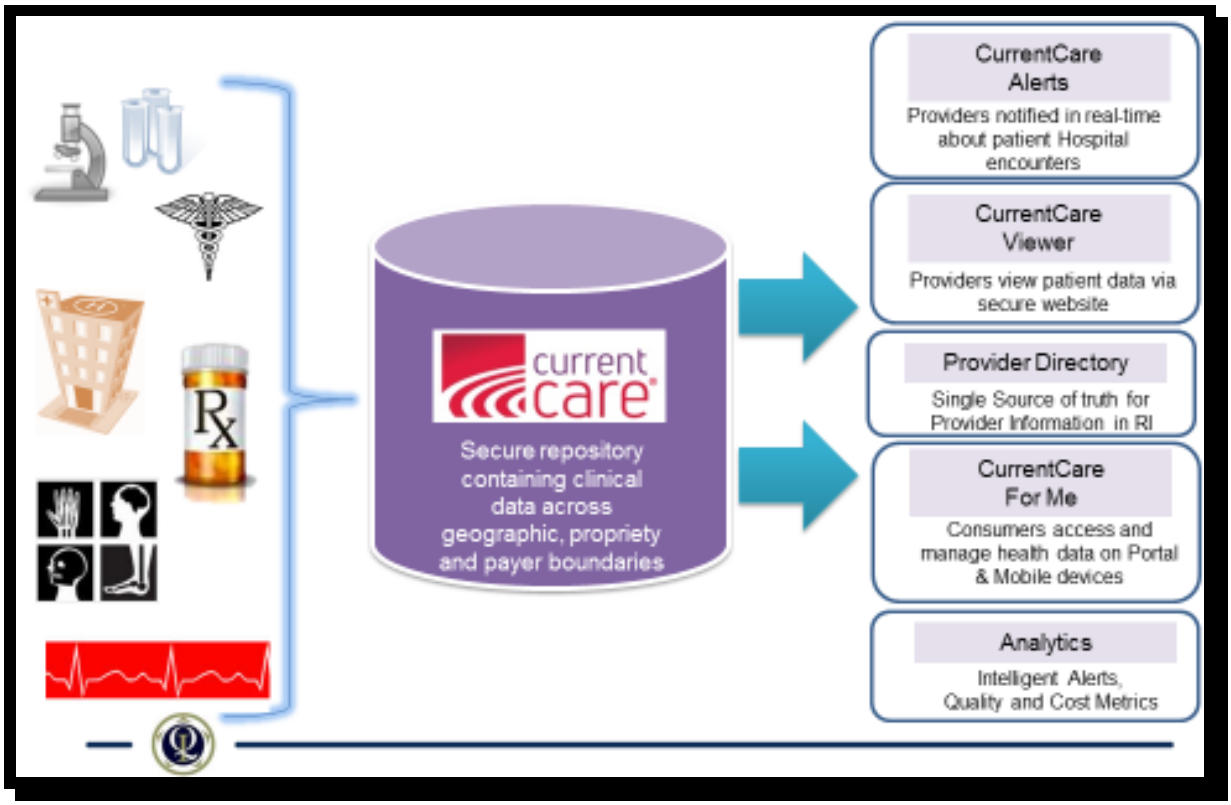
KIDSNET, administered by RIDOH is the state's confidential, computerized child health information system serving families, pediatric providers, and public health programs. It helps ensure that all children in Rhode Island are as healthy as possible by tracking health screenings and connecting children to important early intervention programs. Operational since January 1,

1997, KIDSNET captures information on all children born in the state, as well as from children born out of state who see a Rhode Island participating provider or receive services from a program participating in KIDSNET.

CurrentCare

CurrentCare is the statewide Health Information Exchange (HIE), operated by RIQI, the state's designated regional health information exchange organization (RHIO) entity. Rhode Island's HIE is a secure electronic system that allows doctors and other caregivers immediate access to an enrolled patient's up-to-date health information in order to provide the best possible and most comprehensive care. CurrentCare went live in 2010 and is governed by the HIE Act of 2008, which requires individuals to voluntarily participate in the program. Participants agree to have their data be stored and shared through CurrentCare with provider users they authorize. CurrentCare also provides Hospital Alerts to subscribed providers to inform them of emergency department (ED) or hospital admission, discharge, or transfer of their patients. A CurrentCare Patient Portal is under development and will be tested by a pilot group in the spring of 2016. As of March 2016, there are 435,000 actively enrolled participants, which represents about 43 % of Rhode Island's population.

Figure 50: CurrentCare Data Exchange Diagram



Prescription Drug Monitoring Program

The RIDOH maintains a Prescription Drug Monitoring Program (PDMP0) which collects dispensing data for Schedule II, III, and IV prescriptions from all pharmacies in the state. Prescribers and pharmacists can log in to the PDMP portal to look up dispensing information on patients they are serving, improving the ability of providers to make informed prescribing decisions.

HealthFacts RI

HealthFacts RI is Rhode Island's all payer claims database (APCD). It consolidates an individual's de-identified claims from all payers longitudinally in a central database, preparing the data to be used for analysis to ensure transparency about health care costs, utilization, and quality in the state. The Rhode Island General Court enacted Chapter 23-17.17-9, Health Care Quality and Value Database in 2008, which directed RIDOH to establish and maintain the Rhode Island All-Payer Claims Database and gave the state the authority to require insurance companies to provide de-identified healthcare claims data for services paid on behalf of enrollees. Planning for the development of HealthFacts RI began in 2012 when funding became available, and RIDOH promulgated regulations in 2013. While other funds were used to build the initial HealthFacts RI database with historical data, funding for the ongoing ability to fully implement, maintain, and analyze the data is part of our SIM HIT plan and will be discussed in more detail below.

SIM Test Grant HIT Components

While HIT adoption is continuing to become more prevalent among the larger practices in Rhode Island, many providers, practices, healthcare organizations, and the state itself are struggling to find the resources and means to fully and effectively use EHRs and claims data to drive improvements in health care quality and reduce the cost of care. Given that data continues to aggregate in individual EHRs, in ACOs and health plans, and within projects such as CurrentCare, HealthFacts RI, and RI Bridges, Rhode Island needs an effective, thoughtful, and integrated analytic strategy to support the state's SIM goals and drive health care transformation efforts.

Rhode Island's SIM Health Information Technology Plan has two major strategies:

1) Improve our collective analytic capacity for the data we already have; and
2) Implement technology and tools that support our transformation activities.

There are four major projects in Rhode Island's Health Information Technology Plan:

- HealthFacts RI
- Statewide Common Provider Directory
- Integrated Health and Human Services Data Ecosystem, and
- Healthcare Quality Measurement, Reporting, and Feedback System.

Rhode Island has developed these projects so that they are all interconnected and interdependent. To sufficiently and adequately understand and increase the value of the healthcare being provided in Rhode Island, we are pursuing a value-added central collection of provider data, claims data, and clinical data that goes beyond the siloed data housed at each individual healthcare organization and state agency. The proposed implementation timeline for these activities is incorporated in the Master Timeline. The contributing entities will include payers, providers, and state agencies. When the projects are fully implemented, each system will feed off the knowledge and value-added features located in the others.

HealthFacts RI

SIM Test Grant funds are supporting the implementation and maintenance HealthFacts RI. Its purpose is to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. When fully implemented, it will also provide state agencies and policy makers with the information they need to improve the value of healthcare for our residents. It will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities. HealthFacts RI began collecting data in 2015 and includes historical data from 2011-2014.

Use of HealthFacts RI

With the passage of the Affordable Care Act, 95% of Rhode Islanders are now covered by insurance[93]. Most of their encounters with the healthcare delivery system will result in the payment of a claim processed by one of the insurers in the state, including Medicaid. A claim contains a wealth of health and cost information such as the diagnosis, basic demographic information, provider information, cost information (including total cost and out-of-pocket cost), and type of treatment provided.

[93] http://healthsourceri.com/press-releases/healthsource-ri-reports-uninsured-rate-drops-to-5/

Rhode Island has taken extensive precautions to protect patient privacy in the database, while ensuring that the data is still longitudinal and useful to agencies, legislators, and researchers. HealthFacts RI does not collect any direct patient identifiers and is fully de-identified. A unique member ID allows for longitudinal analysis across payers and time. The APCD legislation also allows individuals to opt-out of having their data collected.

HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers. This information allows users to benchmark and track Rhode Island's health care system in ways that were previously not possible. We can now consider questions such as

1. How do patients of commercial insurers fare on preventable hospital readmissions compared to those in Medicare or Medicaid?
2. How much are we spending on healthcare in Rhode Island and what drives that spending?
3. What do we know about the types of patients who miss critical preventive or disease management services?

As the data collected by HealthFacts RI grows, we will better understand the healthcare delivery system by identifying areas for improvement, growth, or contraction; we will be able to better quantify overall health system use and performance; we can more effectively evaluate the effectiveness of policy interventions, and assess the population's health.

One of the great benefits of creating a database like this is that individuals can be tracked over time, even if they change insurers. With HealthFacts RI, analysis of the lifespan will be possible to help understand, for example, the scope of an entire health episode (i.e. an entire knee replacement and recovery, severity of illness, or potentially preventable events).

Table 15 describes potential state agency uses of HealthFacts RI, and Table 16 describes potential non-state user uses of HealthFacts RI. These analyses will support a host of new activities under value-based payment. Policy makers and researchers will use this knowledge to inform the way care is delivered and paid for, in order to move the system toward a higher-quality, greater-value paradigm.

Table 23: Potential Use of HealthFacts RI by State Agencies

Audience	Potential HealthFacts RI Uses
Department of Children, Youth and Families	• Spot trends in groups of children with lead poisoning and help identify safer environments for children to live and play • Identify patterns of access to care for children with behavioral health conditions or diagnoses • Explore patterns of children who visit the ER frequently for non-emergent conditions
Department of Health	• Monitor trends in disease prevalence, co-morbidities, and emerging infectious diseases • Design and evaluate interventions to address trends in opioid and prescription drug abuse • Monitor prescription refill patterns as a proxy for medication adherence monitoring • Understand patterns in care migration and service use outside of Rhode Island to support the Certificate of Need process Monitor and use data to promote screening and prevention services
Department. of Human Services	• Better understand the medical experience of demographic groups that receive DHS benefits, such as WIC and SNAP • In order to better tailor benefit and service experiences, monitor trends in patient health, spending, and use by zip code to find similar demographic groups
Division of Elderly Affairs	• Test, evaluate and monitor the effect of different long term care arrangements on patient health and spending • Compare duration, intensity, and types of service use for elders who continue to live in the community versus those who enter nursing home care • Create profiles to help predict elders at risk of missing needed care
Healthsource RI	• Develop portraits of those enrolled in plans sold through HealthSource RI compared to rest of state • Understand how people use health care when they have different types of insurance coverage • Better understand patterns of coverage churn • Monitor patient out-of-pocket comparisons by plan type/metal value
Medicaid	• Monitor, both all-cause and preventable hospital readmissions by provider, demographic, year, geography, admitting diagnosis, or post-discharge services. Compare to other payer types. • Analyze the use of appropriate care settings: trends in ED, clinics, or office visits • Understand the effect on patient health care of interventions, such as long term care rebalancing and the transition to Accountable Entities • Monitor the types of outpatient services used after a hospital discharge for those who are and who are not readmitted
Office of the Health Insurance Commissioner	• Provide information about costs of services to consumers • Review cost trend drivers to support rate review • Compare increases in actual medical spending versus premium payments • Monitor out-of-pocket spending and total cost of care • Project effects of hospital system consolidation on price
State Innovation Model (SIM)	• Support modeling and evaluation of new payment designs • Establish baseline and quantify total spending for patient cohorts attributed to particular practices

Table 24: Potential Use of HealthFacts RI by Non-State Users

Audience	Potential HealthFacts RI Uses
Consumers	• Quality and cost information for different products, carriers, and provider groups or health systems
Payers	• Risk-adjusted payment comparisons • Program evaluation • Health reform initiatives • Provider-specific measures (utilization and quality) • Methodologies for attribution, risk-adjustment, and predictive modeling • Information on behavioral health • Market analysis
Providers	• Risk-adjusted peer comparisons for practice improvement and transformation • Referral costs • Patterns of care (flow of patients to other specialists, etc.) • Episode groupers • Market analysis

Researchers	• Wide range of research projects to be approved by Data Release Board, such as:
	  ○ Epidemiology
	  ○ Evaluation of program effectiveness
	  ○ Comparative effectiveness

Other Commercial Users	• Pharmaceutical, medical device trials and research to be approved by Data Release Board • Market analysis

Additionally, HealthFacts RI data will be available by request to any number of stakeholders, include nonprofits, other state governments, and researchers. While some aggregated data sets are posted on the RIDOH website, detailed line level data sets can be released after review of an application. These line level data sets do not contain any identifying information; however there are scenarios where there may be enough information that when combined with another dataset an individual could be identified. To help reduce the chance of privacy violations, the RIDOH Director convenes the All Payer Claims Database Data Release Review Board, an eleven-member advisory board, to review applications for data. The purpose of the board is to ensure that data requestors will maintain patient privacy. We will begin releasing data through this process in the second half of 2016. Any data release which has a potential to identify any individual will only be released with an appropriate Data Use Agreement (DUA) between RIDOH and the recipient. Additionally, the Data Release Review Board will take into consideration the recipient's ability to secure and protect the data when making a recommendation about data release.

Value-based healthcare requires transparency.[94] Meaningful cost and quality information is key to building a healthcare system that pays for quality and outcomes instead of more services that may or may not improve patient health. However, despite years of measurement efforts, patients, employers, public purchasers, health plans, and even providers, have almost no reliable information about the relative cost and quality of healthcare services. Payment reform and delivery system redesign are front and center as national priorities – and to make them

[94] http://www.nrhi.org/work/multi-region-innovation-pilots/center-healthcare-transparency/

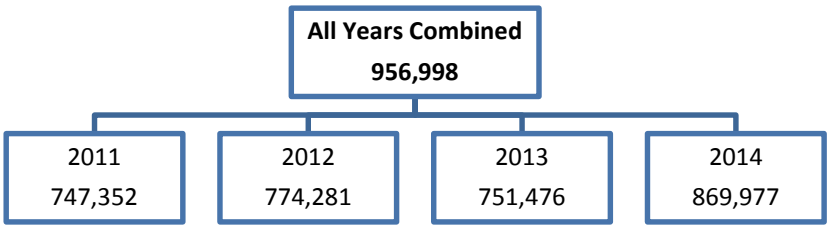
work, we need transparent performance information to know that we are paying for the right care at the right cost.

Status of HealthFacts RI
HealthFacts RI includes claims data for any commercial, self-insured, Medicare, and Medicaid entities which covers over 3,000 lives. The database includes membership, paid medical claims, paid pharmacy claims, and provider data from 2011 to present. Data collection began in 2014, and currently comes from seven commercial and two public payers. In 2016, we will on-board two additional commercial payers, CVS and BCBS of MA. State users have access to data as soon as six months after the service happened.

Table 25: Payers submitting data to HealthFacts RI

Commercial Payers	Public Payers
Blue Cross & Blue Shield of Rhode Island	Medicaid
United Healthcare	Medicare (Parts A, B, D)
Neighborhood Health Plan of Rhode Island	
Tufts Health Plan	
Harvard Pilgrim	
Aetna	
Cigna	
In-process: CVS and Blue Cross Blue Shield of Massachusetts	

Figure 51: Unique Covered Lives in HealthFacts RI Database



Governance of HealthFacts RI
HealthFacts RI is managed by an Interagency Staff Workgroup made up of representatives from four state agencies: EOHHS, HealthSource RI, RIDOH, and OHIC. This workgroup meets weekly to monitor the progress of the vendors' work and to plan next steps. The agency principals are kept up to date on the status and asked to weigh in on major decisions through regular meetings. (Please note: because of state privacy laws, there cannot be coordination between CurrentCare and the APCD governance.)

As mentioned above and as required by statute, there is an APCD Data Release Review Board whose purpose is to ensure that data requestors such as researchers, program evaluators, payers etc., will maintain patient privacy. HealthFacts RI will be ready to start releasing data files to requestors in the second half of 2016. In response to the recent U.S. Supreme Court ruling in *Gobeille v. Liberty Mutual*, Rhode Island issued a memo to data submitters informing them that

the decision does not apply to HealthFacts RI because the statute enacting the APCD is very different from the Vermont statute reviewed by the Supreme Court. Rhode Island imposes reporting requirements on insurers – not ERISA governed self-insureds. There is no personally identifiable information in the database, and individuals are given the opportunity to opt out of the database.

SIM Funding of HealthFacts RI

The HealthFacts RI SIM project consists of three vendor contracts – project management, data aggregation, and analytics vendors.

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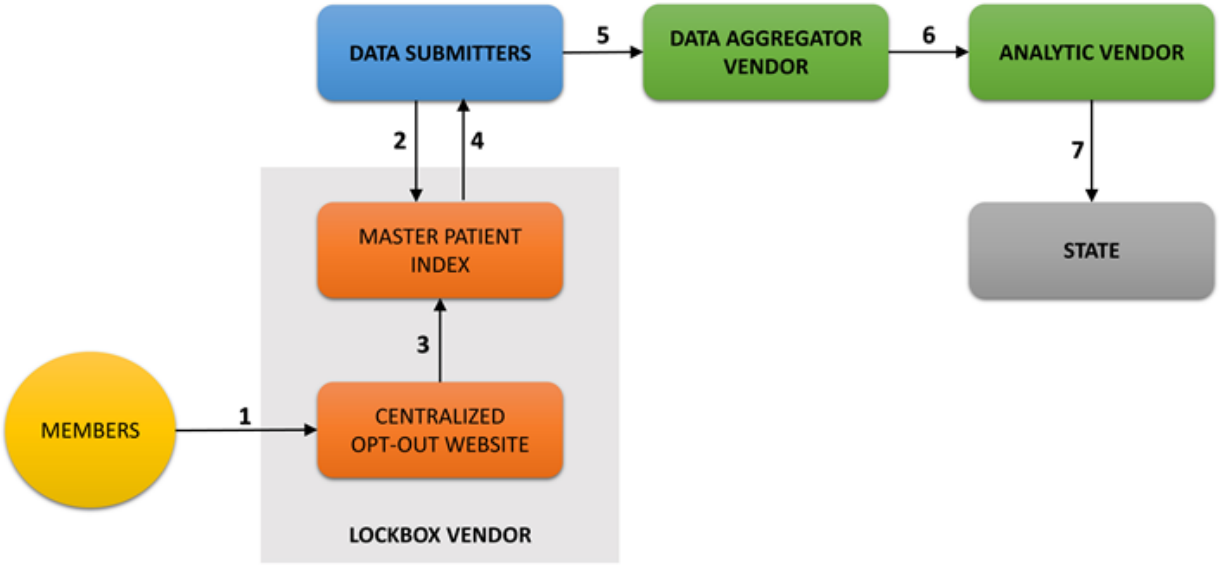
Figure 52: HealthFacts RI Infrastructure Diagram



Freedman Healthcare provides project management and subject matter expertise for HealthFacts RI The project management team organizes meetings, manages communications, coordinates with the vendors, and manages the data release process.

Our data aggregation vendor, Onpoint, subcontracts with Arcadia Healthcare to facilitate the data de-identification process, which allows for people to be matched longitudinally across payers while keeping individual identities masked. Payers submit their member eligibility files on a quarterly basis and receive a Unique Member ID (UMID) back to incorporate into their systems. Arcadia also maintains an opt-out website and the Rhode Island Health Insurance Consumer Support Line allows individuals to opt-out over the phone.

Next, the payers submit fully de-identified member eligibility, provider, medical claims, and pharmacy claims files to the data aggregator (Onpoint) including the UMID assigned by Arcadia in place of names and other sensitive identifiers. The data aggregator applies data processing rules to combine files together to construct the database.

The underlying data is then sent to our analytics vendor, 3M HealthCare, which provides additional analytic data processes and applies a variety of analytic value-adds to the data. The analytics vendor hosts a web-based analytics tool that provides state agency employees the ability to analyze the data in a visual way.

Statewide Common Provider Directory

There are three important reasons that SIM prioritized funding the creation of a Statewide Common Provider Directory:

1) Payers, providers, and consumers alike need access to accurate provider information, including current provider name, address, and contact information, and practice affiliations, specific health plan network information, and direct e-mail addresses. In order to maintain accurate provider directories for facilitating payment, care coordination, or data analysis (such as with HealthFacts RI), each type of organization expends considerable resources attempting to maintain their directories. One statewide directory provides economies of scale for both dollars and time.
2) Per legislation, CurrentCare offers three consent options for providers to view data: in emergencies only, to only specific providers, or to all providers. Facilitating the option that only specific providers can view a participant's HIE data requires an accurate provider directory.
3) Finally, there is no central location from which to identify the total number of providers (including primary care providers) practicing within Rhode Island or to identify how providers are affiliated. It is difficult to determine, for example, who belongs to what "practice," with which hospital a provider is affiliated, or how many physician practices exist in the state, etc. In 2015, RIDOH conducted a Statewide Healthcare Inventory of all services and providers in the state. A team of eight interns worked through the physician licensing database and determined whether each physician was actively practicing, practicing primary care, and the location of their practice(s). Thus, collecting this data required a considerable amount of manual work and phone calls – and we will need updated data in 2017 when the survey is conducted again. The Common Provider Directory will cut down on this type of duplicative activity going forward.

Using SIM funds, Rhode Island has contracted with RIQI to build our Statewide Common Provider Directory, which will include detailed provider demographics and detailed organizational hierarchies. This organizational hierarchy capability is unique and essential to being able to maintain provider demographic and contact information, with a special focus on provider relationships to practices, hospitals, ACOs, and health plans. The Directory will mean that the mastering and maintenance of provider information and organizational relationships will take place only once, in a central location.

The provider directory is a database with a web-based tool that allows a team of RIQI staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, manually update provider data, or enter new providers. With the appropriate data mastering and maintenance system in place, RIQI expects to have a useful data export via a flat file ready with a go-live in June 2016. These data exports will allow hospitals, payers, and state agencies to incorporate the centrally mastered provider data within their own databases.

The provider directory will have a provider portal which will allow providers to look up information on other providers that may not be public such as "direct" email addresses and to update their own data as needed. It will also have a consumer portal which will allow individuals to access information on providers and provider organizations. The design of these portals will take place in 2016, with the anticipated go-live in early 2017.

Project Management
RIQI manages this project in partnership with a Provider Directory Advisory Committee (PDAC). The PDAC consists of RIQI leadership and provider directory staff, representatives from the major stakeholder state agencies (RIDOH, EOHHS, HealthSource RI and OHIC), the HealthFacts RI project management vendor, and most recently payers and providers. The group has been convening at least monthly, with additional meetings as needed. The PDAC has overseen the creation of data stewardship and survivorship rules, and acts as an advisory body over the design and implementation of the provider directory. RIQI has recently decided to formalize the committee even more and is planning to add other community members in order to obtain broader input and advice regarding rules and assumptions about provider data. For example, when the PDAC began designing a sample extract, it invited providers into the discussion to inform RIQI about which extract elements are important to share publically and which data elements are considered too sensitive to share, such as birth date and/or DEA number for writing prescriptions.

Directory Data Sources
The Statewide Common Provider Directory is being developed by RIQI with their HIE vendor, Intersystems. It was decided early on that the Healthcare Provider Directory (HPD) standard would not meet the business case needs, and so an independent data model has been constructed with a goal to make it extensible and flexible to fit future unforeseen needs.

The Provider Directory can receive multiple data feeds and matches those feeds based upon NPI (national provider identifier), provider name, etc. The initial data sources include the NPPES national database of providers, a purchased dataset from HealthMarket Science, RIQI's internal database maintained from its role as the state's Regional Extension Center, and a file from one of the major hospital systems in the state. Future data sources include the payers, the Department of Health's licensing database, Medicaid provider database, APCD provider files, and data from additional providers or provider networks. Not all prospective organizations perceived as data sources have agreed to supply their own provider files, especially due to concerns about sharing of private or proprietary information. In order to reduce this risk, Data Use Agreements can incorporate special sharing rules, and the submitting organizations are encouraged to participate in the PDAC which will also make data sharing governance rules. The PDAC is also working on an effort to reduce the burden on payers to submit provider files to both the Provider Directory and HealthFacts RI.

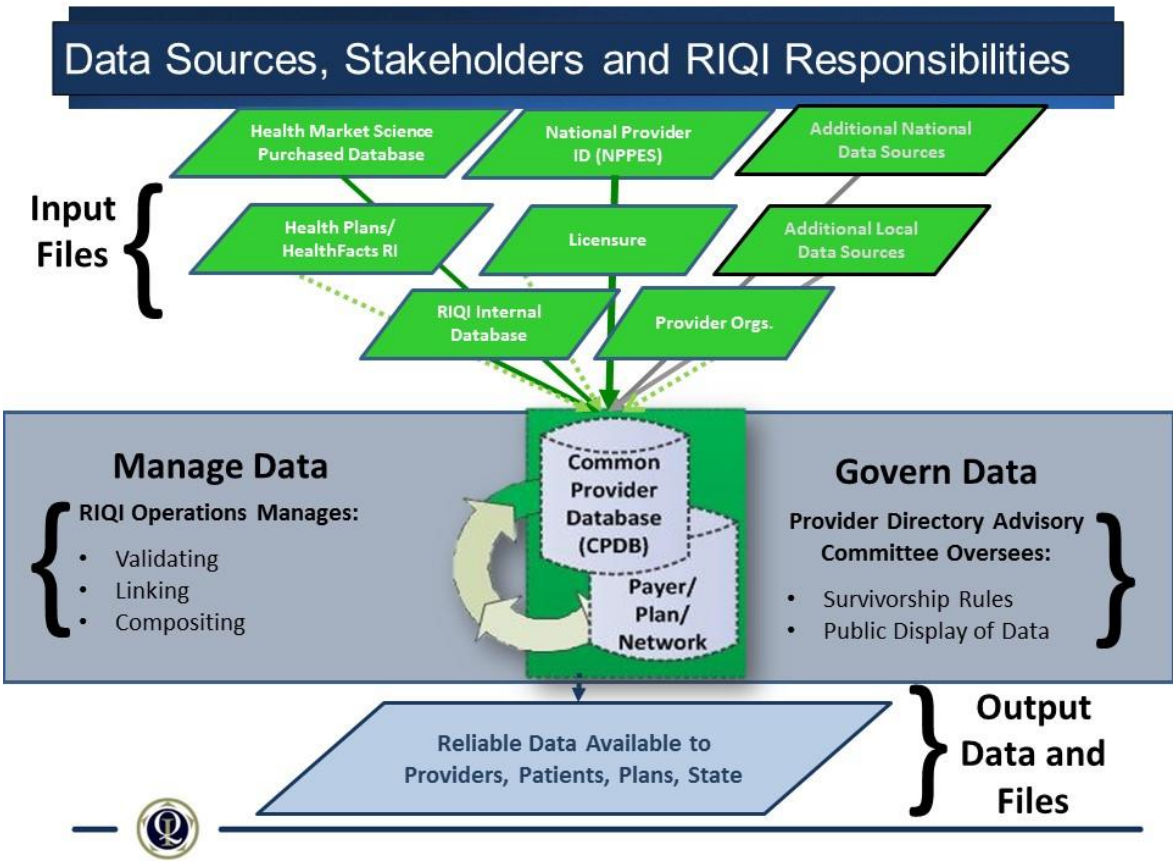
Looking Forward
Upon the launch of the provider and consumer directory portals, we will provide be training and assistance around how to use the website, how to create a user account for providers to update their own data as well as how to update their own data. We will also provide consumer announcements and support for using the website, including mechanisms to report errors and other instructions.

There are numerous ways that the Provider Directory can be used to support a variety of stakeholders. We foresee the directory as being of great value to the community, and RIQI plans to provide directory extracts at a subscription style fee in order to help sustain the directory and the necessary staff in the future. Table XX describes the various interested stakeholders and potential uses of a Provider Directory.

Table 26: Potential Use of Provider Directory

Audience	Potential Provider Directory Uses
State Agencies	• Reduce resource needs to maintain internal provider directories • Support analytic needs, such as with HealthFacts RI analyses
Consumers	• Find a provider that fits the consumer's preferences
Payers	• Support Qualified Health Plans and Medicare Advantage Plans in meeting regulatory requirements from CMS • Understand the scope and location of providers for network design • Support a more accurate internal provider directory
Providers	• Find providers for referrals • Support a more accurate internal provider directory • Communicate to consumers more details about offered services
Researchers	• Comprehensive understanding of the RI Healthcare system • Evaluation of intervention impacts on access to healthcare services
Other Commercial Users	• Support a more accurate internal provider directory • Contact information for a variety of commercial purposes

Figure 53: Provider Directory Conceptual Diagram



Integrated Health and Human Services Data Ecosystem

SIM aims to transition the state's health care system to one dominated by value-based care, thereby lowering costs and improving population health. The data ecosystem, a project-based network of linked person-level data and the technological systems that support its use, undergirds these goals by supporting (a) data-driven and surgical approaches to improving and monitoring population health and (b) holistic evaluations of our transition to Value Based Care.

Value based care and population health rely on understanding the whole person and the complete characteristics of a target population in order to tailor interventions to their needs – to meet people where they are. We also know that social determinants of health – measures that go beyond what can be captured on a claim, or even in a medical record – are stronger levers on healthcare spending and population health than purely medical factors.

The Rhode Island Executive Office of Health and Human Services holds rich sets of data for each of the programs and agencies it administers, many of which reflect social determinants of health, income supports and medical interventions. Our agencies often provide services to the same people. However, they remain unlinked, supporting only the program or agency from which they originate. Tying this information together at the person level will allow not just state government, but the state generally, to run smarter, more complete value based care arrangements that target specific populations and their unique needs. Data can then be used at both the individual level to provide better services and reduce gaps in care and services, and in the aggregate to drive overall policy decisions. The ability to share health and human services data across the EOHHS agencies is clearly permissible by state statute and will allow for a more complete evaluation of both the overall trajectory of care transformation and the relative success of different kinds of, and providers of, value-based care. Additionally, we will identify what policies, procedures, authorizations and data use agreements will be needed prior to engaging in data sharing initiatives with non EOHHS state agencies,

For instance, by linking KIDSNET data – vital information on children in Rhode Island hosted by RIDOH – with Medicaid and eventually commercial enrollment data, child welfare information, and income support services for the child's family, we can begin to answer question such as:

- Which high utilizers or particularly high risk families and individuals are not enrolled in an Accountable Entity or Accountable Care Organization? Which have not seen a primary care clinician for either well or sick visits and are showing signs of social and income deterioration that may not have yet impacted claims costs? Can we get in front of a potential medical catastrophe by proactively linking these patients to focused care management and wrap around services?
- How do we best alert ACOs that some of their attributed children have had a positive screen for Early Intervention services, for lead levels, or for nurse home visiting and support them in providing need enhanced social worker, nurse care manager, or other medical and social support?
- What services, education, or other resources (based on known medical conditions from Medicaid and BHDDH claims) can the ACO bundle into a state-provided nurse home visit to maximize family engagement with preventive and behavioral health care?
- For families of children who screen positive for birth defects, high lead levels, or other points of stress in critical developmental years, what can an ACO do to ensure families remain enrolled in income supports and the other critical social services that they are receiving?

- Which Medicaid high utilizers, when combined with social support, economic, demographic, and other social determinants of health information, are most likely to benefit from case management interventions? Who are most likely to be homeless and benefit from home stabilization services, thus lowering costs?
- If one person in a family is a high utilizer, how can an ACO help the whole family maintain stability and thus lower medical costs and avoid high acuity settings?
- If the family received WIC, SNAP, or TANF, could an ACO build into the family's care plan reminders for renewals and support for interacting with DHS if benefits are interrupted? Can care plans emphasize self-care for known chronic diseases that will flare without attention (theoretically exacerbated by stress, focusing on the care of others). Can care managers inform families of low-acuity alternatives for emergency rooms, ambulance transport and urgent care centers? For high risk cases, can care managers train families on how to manage, identify signs of true emergency at home?

The data ecosystem will eventually cover nearly every person in Rhode Island, linked at the person level, with identifiers and the ability to link to data outside of EOHHS – to the Rhode Island Department of Education (RIDE), to the Department of Corrections, and to wage and employment data from the Department of Labor and Training (DLT). This scalable and sustainable model will be developed in a manner that complies with all state and federal privacy statutes and will enhance our ability to measure holistic outcomes of our residents as we transition to value-based care.

Though the initial emphasis, as envisioned and funded by SIM, will be on those who interact with EOHHS programs, even this focus provides basic data on a broad swath of Rhode Islanders through Vital Records and KIDSNET. Beyond the basics, we will have rich and complete data on those who enroll in Medicaid, receive income supports through DHS, are involved in the child welfare system or are among the 50,000+ people who are served by BHDDH. The benefit to this design is that we will know more about our most vulnerable population group, those who most benefit from holistic interventions in social determinants of health.

Phases and Milestones

Initial Phase: July 2016 through July 2018

- **Year 1**: July 1, 2016 -June 30, 2017
    - Complete the data warehouse and analytic environment assessment (currently in progress and funded through other sources)
    - Use the findings of the assessment to prioritize 1-3 research questions that rely on linked data, execute data linking pilots and test existing capacity. What skills, tools, and knowledge does the state have already and what does it lack? Which are most critical to supplement? What is the best way to supplement – through training, through software-as-service, through licensing and hosting services, through hands-on teaching and training of ETL (Extract, Transform, and Load) and data modeling, through contractual arrangements with staffing vendors?
    - Based on results of assessment and pilot, hire a limited number of strategic staff, such as a database administrator, a database architect, or an ETL or Data modeler
    - Based on results of assessment and pilot, write and issue an RFP for project-based ecosystem launch services. Aim to have the vendor signed by July 1, 2017.
    - Begin to assess state and federal statutes for sharing data with non-EOHHS state and other agencies and gain an understanding of what is needed to enable data sharing

- **Year 2:** July 1 2017 – June 30 2018
    - Within the agile data warehouse design framework, the vendor integrates EOHHS data sets on a project specific basis using either the servers and capacity at state data center or the existing HHS warehouse
    - Vendor builds a master client index generator for extensive future use
    - ETL scripts and data models are built with the expectation of handoff to state; extensive state partnership and documentation are required
    - Vendor builds a user interface on top of data model to facilitate widespread use of the integrated database among agencies
    - A key component of the teaching is how to strategically integrate a new dataset at the person level, which the state staff will be expected to do with non-EOHHS datasets

Phase II:

- **Year 3**: July 1, 2018-June 30, 2019
    - Over the course of the year, vendor transitions ecosystem to state and/or contractual staff
    - Permanent staff gain experience in model maintenance, trouble shooting, and enhancements to the architecture, interface and value-added components based on customer need
    - Begin to incorporate data from outside EOHHS
- **Year 4**: July 1, 2-19-June 30, 2020
    - Transition to state staff complete
    - Critical datasets, both within and outside of EOHHS, are incorporated into ecosystem
    - Implement policies, procedures, authorizations, and data use agreements to enable data sharing outside of EOHHS.

Healthcare Quality Measurement Reporting and Feedback System

As noted throughout this document, Rhode Island's SIM project is focused on the transformation of our health system from one based on volume to a system based on value. During the past year, stakeholders helped SIM study community needs, and determined that SIM should prioritize funding for a Healthcare Quality, Measurement, Reporting and Feedback System (Feedback System).

Having reliable and consistent clinical quality data is an absolute requirement for measuring quality within a value-based payment system. While some clinical quality measures can be calculated from claims data only, there are many that must be calculated from clinical data recorded in patient medical records at the points of care.

There are several initiatives within Rhode Island that require providers to submit clinical quality measure data. These include:

- The Care Transformation Collaborative' s multi-payer primary care and patient centered medical home transformation initiative (CTC),
- Payers' contractual requirements,
- The RIDOH Chronic Care Collaborative (RICCC), and
- A myriad of national level quality initiatives such as the EHR Incentive Program, ACO program, Physician Quality Reporting System (PQRS), and National Committee for Quality Assurance (NCQA) certification programs.

The CTC and RICCC processes to collect quality measures involve manual report calculation at many of the participating practices using National Quality Forum (NQF)-based home-grown

measures, and there is no guaranteed consistency in the measure calculation across all participants.

Emerging standards and the 2014 Certified EHR Technology (CEHRT) standards support more consistent quality measure reporting across different EHR vendors as compared to a manual reporting pull. Furthermore, there is a considerable burden upon payers to have quality reporting systems in place in order to receive their certification through NCQA. The data received by payers in claims alone is not sufficient nor accurate enough to forgo the manual audit of patient records at the point of care or the acceptance of a certain level of unreliability in the quality metric.

Three 2015 studies shed light on Rhode Island's data needs The studies indicate that there is a lower-than-desired capacity to perform data analytics in the state, but that providers and others do have the intention to spend great sums of money to support analytic needs. RIQI conducted an analytics inventory at the request of their Board of Directors. This inventory was conducted through a survey of state agencies, and a range of provider organizations (large, small, independent, hospital affiliated, federally qualified health centers, community mental health centers, etc.), as well as payers, educational institutions, and community partners in the state. The study found that respondents had a need to calculate numerous high priority measures (including ambulatory quality measures, identification and management of high-risk patients, and analysis of utilization/cost of care indicators). However, these entities did not all have the systems in place to measure the information they needed. Only 76% of providers could collect ambulatory quality measures. Only 68% of providers could identify and manage high risk patients,, and 56% could measure utilization/cost of care indicators. Furthermore, the level of satisfaction with those analytic systems was extremely low. Half of respondents planned new systems for identification and management of high risk patients, and around 20% planned new systems for ambulatory quality measures and utilization/cost of care analysis.[95]

We also find important data about EHR adoption rates in RIDOH's Statewide Healthcare Inventory. The survey found that there was wide disparity practices' ability to analyze data. While 85% of hospitals had reporting software to help analyze data only 52% of nursing facilities, 26% of primary care practices, 23% of behavioral health clinics, and 17% of outpatient specialty practices had this software, as shown in Table 17.

Table 27: *EHR Adoption Rates Compared to Availability of Reporting Software, by Location Type, RIDOH Statewide Healthcare Inventory, 2015*

Survey	EHR Adoption Rate	Reporting Software
Primary Care	82.6%	26%
Outpatient Specialty	72.7%	17%
Behavioral Health Clinics	39.6%	23%
Nursing Facilities	80.9%	52%
Hospitals	92.3%	85%

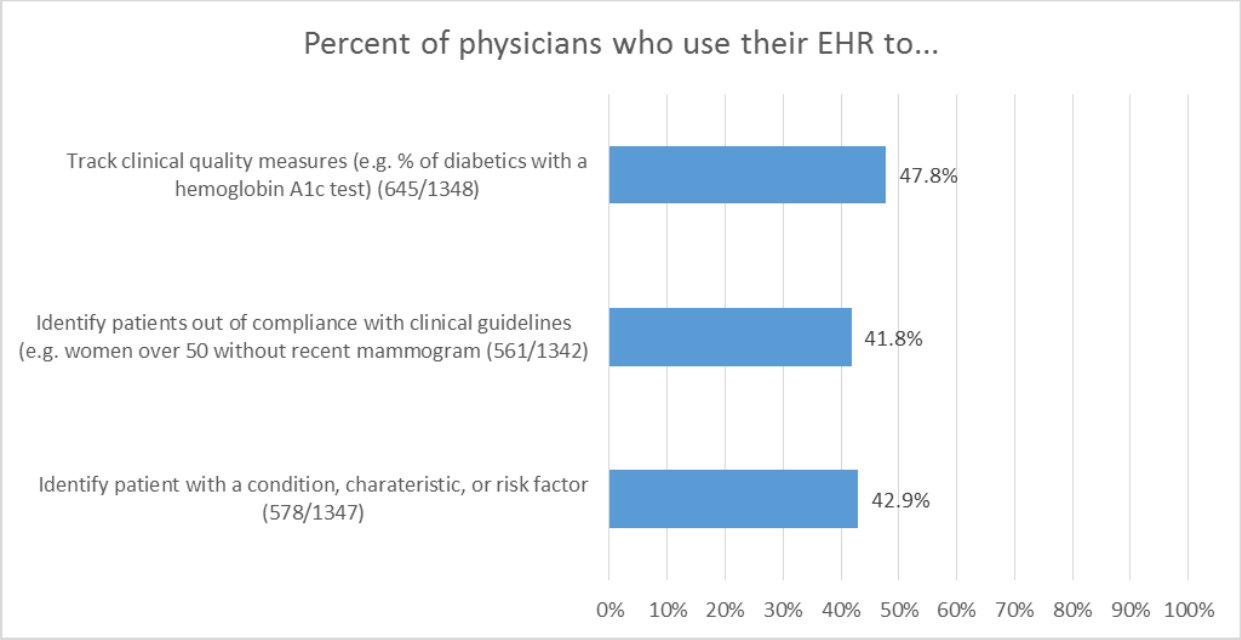
Providers were also surveyed about their use of EHR Technology from a population health perspective. Out of the 1,350 respondents, only 34.2% reported that they are using their EHR for population health management, 31.1% were not, and 24.7% did not know. However, compared

[95] Rhode Island Quality Institute Analytics Inventory, 2015.

to 2014, the number of respondents using their EHR for population management increased 7.8% and those who did not know decreased by 7.1%. This indicates that there is a shift to population health and to reducing the cost of healthcare with EHR technology.

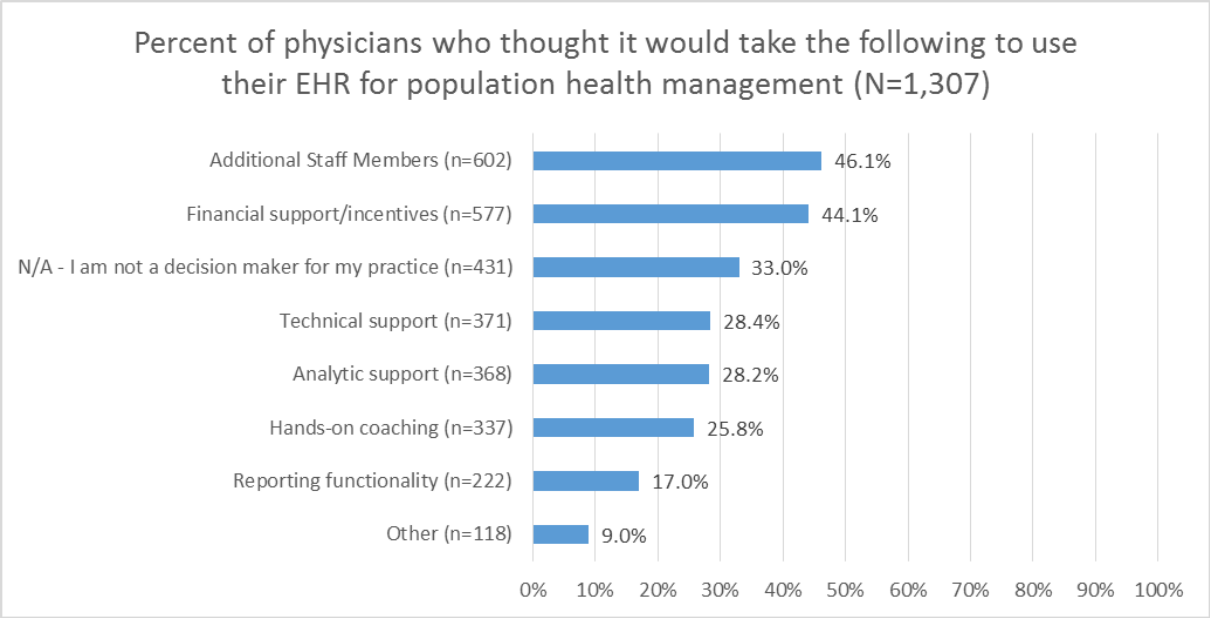
One of the goals of the physician survey was to identify the provider's use of their EHR to track quality measures and population health. Almost 50% of our providers are using their EHR for clinical quality measure monitoring and for patient reminder messaging.

Figure 54: HIT Survey, Physician Use of EHR, 2015



The HIT survey also measured the barriers preventing providers from using their EHR for population health. As noted in the Figure 10, the primary reason that providers did not use the EHR for population health was the lack of adequate staff or financial support.

Figure 55: 2015 HIT Survey, EHR Use for Population Health Management, 2015



These data indicate that providers in the state are not prepared to measure and understand their own quality of care, much less proactively address gaps in care that lead to low quality measure performance.

Feedback system Year 1 (Planning)

A number of stakeholders considering these challenges have been participating in the SIM Technology Reporting Workgroup at the behest of the Steering Committee. The workgroup is led by the State HIT Coordinator and the HIT Specialist hired specifically for SIM. It began meeting in January, 2016, and consists of representatives from state agencies, payers, provider organizations, and quality improvement organizations. The workgroup also conducted a survey of healthcare providers in the state in order to receive additional input on the concepts we were considering for the Feedback System. The Workgroup and the Steering Committee endorsed the development of a central quality measurement, reporting and feedback system to address this lack of readiness. However, we have learned through stakeholder feedback that in order to pay for quality, there must be:

- Confidence that each participant is being measured consistently. This cannot be dependent upon the EHR vendor used at the participant's service location.
- Cost alignment – i.e. the cost of measuring the practice should not exceed the benefits of high value cost arrangements
- Confidence in the accuracy of the measurement
- Arrangements that risk adjust, even if the data itself cannot be risk adjusted – i.e. leniency for specific practices that are known to have more complex populations.
- Confidence in the attribution of a patient population to a specific practice.

The benefits of calculating measures centrally include:

- Consistent attribution methodology
- Consistent measure methodology
- Potential for lower costs to practice for measurement; potential for lower costs to payers for measurement
- Potential for risk adjustment that could be consistent

The Workgroup proposed a set of goals and features for this system and the SIM Steering Committee approved the following proposal at the February 11, 2016, Steering Committee Meeting:

Figure 56: Technology Reporting Workgroup Recommendation to SIM Steering Committee

Providers, ACOs and facilities in Rhode Island have a variety of reporting requirements which will only increase under a value-based payment system. Numerous sources support the assumption that analytic resources and capabilities are insufficient in the state to empower providers and organizations to most effectively use their ever-growing and extremely valuable data. Furthermore, numerous organizations in the state are working toward creating their own quality measurement systems that will meet their needs, including payers, practices, and practice transformation organizations.
With this understanding of our current environment, the Technology Reporting Workgroup recommends funding the development of a statewide quality reporting system with the goals of:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations and hospitals about their performance based on quality measures
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting
- Publically reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions
- Using existing databases, resources and/or systems that meet our needs, rather than building from scratch

The Workgroup has determined that in order to achieve these goals, the system would need serve as a common platform for quality measurement, quality improvement, and reporting. It would need to be able to accomplish the following, at a minimum:

- Easily capture data in a standard and consistent manner (no extra work for providers)
- Calculate measures from our SIM harmonized measure set and relevant national measure sets
- Become a Qualified Clinical Data Registry (QCDR) to allow the reporting of results directly to CMS, NCQA, and the payers, and fulfill additional reporting obligations on behalf of providers
- Benchmark providers at the provider level and the provider organization level
- Consist of detailed, individual level data from multiple sources matched to a single person, and make that data available to providers to improve individualized care while appropriately protecting confidentiality
- Share analyses and results back to providers, provider organizations, payers, state government, and, eventually, the public

This project should begin with a focus on collecting data from practices with Electronic Health Records (EHRs). In addition, the state must set up a governance structure with adequate community and provider engagement to determine what data is shared to whom and how it is shared.

There are multiple levels of governance necessary for the statewide Healthcare Quality Measurement, Reporting, and Feedback System, and for now, the Technology Reporting Workgroup will continue to advise state staff on the fundamental goals and features of the system that would best support the collective needs of the community. We will use the output of the Technology Reporting Workgroup as we write and issue a request for proposals. The state

procurement team will consider the Workgroup's feedback throughout the procurement process.

We are currently designing the infrastructure of this system and will begin the competitive bidding process to procure a vendor in June 2016. We can envision this system collecting data from a variety of sources, ideally leveraging existing infrastructure; collecting and mastering the data within a data intermediary, and analyzing and viewing those data through an analytics engine with external public and provider facing website. See Figure below.

Year 2-4 - Implementation
Once the vendor(s) has been procured, the SIM HIT Specialist at EOHHS will oversee the vendor contract(s) and begin the process of establishing this system. This work will take place over a series of phases. Some details of the timeline will be determined based upon vendor proposals.

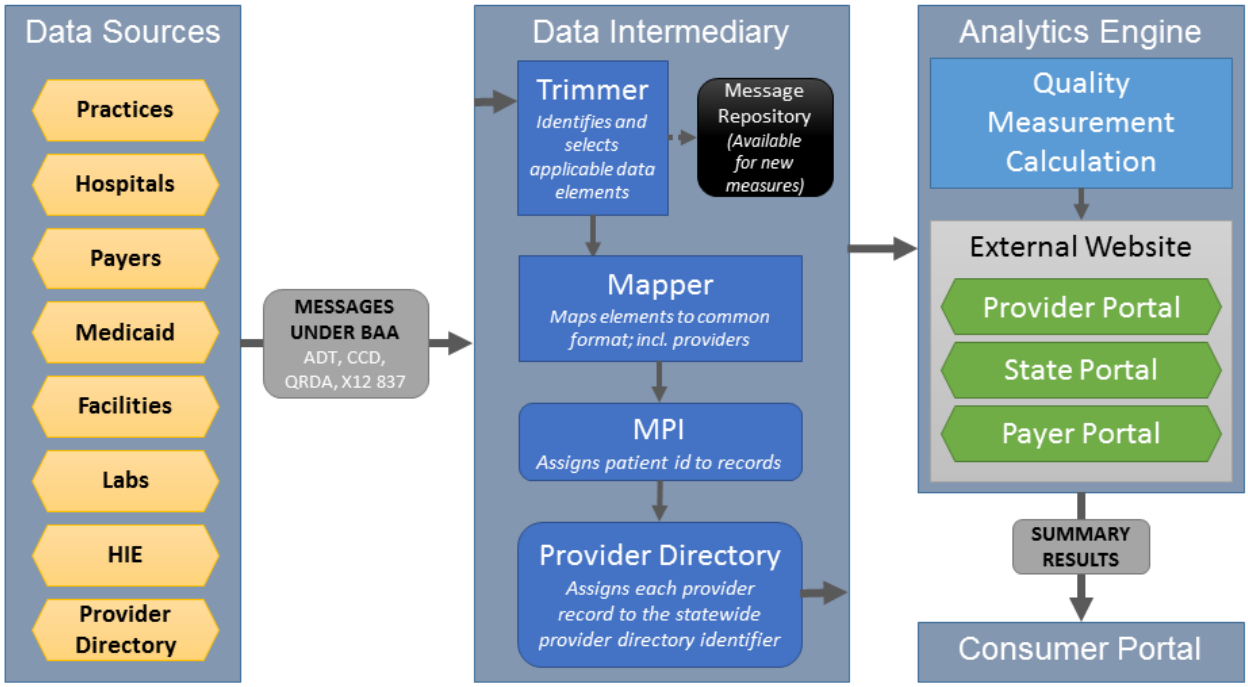
Initial Phase: July 2016 through 2018

- **Year 2**: July 1, 2016 -June 30, 2017
    - Procure vendor
    - Initial setup and deployment of technology
    - Link with existing data sources, such as the HIE, Provider Directory, HealthFacts RI (as allowed by applicable laws)
    - Provider Portal Launch
    - Pilot group onboarding, training, and testing with initial measure set
    - Data quality improvement with EHR vendors
    - Technology Reporting Workgroup meets to establish governance rules
- **Year 3:** July 1 2017 – June 30 2018
    - Qualified Clinical Data Registry (QCDR) certification
    - Payer Portal Launch; State Portal Launch
    - Second pilot group onboarding, training and testing
    - Add expanded measure set
    - Data quality improvement with EHR vendors
    - Technology Reporting Workgroup meets to establish governance rules

Phase II: Operationalization

- **Year 4**: July 1, 2018-June 30, 2019
    - Open to any customers
    - Consumer Portal Launch
    - Technology Reporting Workgroup meets to maintain governance rules
    - Continuing onboarding of providers
    - Additional measures added

Figure 57: Conceptual Diagram, Clinical Quality Measurement, Reporting, and Feedback System



This system will require fully engaging a variety of providers and their staff. We will provide training on the provider website itself and practice coaching for how to utilize the provider portal within the clinical and care management workflows.

Once the system is procured, we will convene a new governance group with the appropriate stakeholders to inform the state on the level of data sharing and benchmarking that should occur between providers and the state, between the state and providers, and with consumers. This was a strong recommendation of the Technology Reporting Workgroup and also arose as a priority in the provider survey.

There are numerous policy and regulatory levers that various state agencies could use to promote the use of this system. For example, OHIC could include its use as part of the SIM aligned measurement initiative. Levers would only be applicable once the system were fully implemented, tested and operating smoothly

Additional HIT Activities

Besides the four major projects described above, SIM is also planning to fund at least three additional projects that include HIT components as tools to support transformation activities. These projects will be prioritized and managed by existing state HIT governance in collaboration with the Steering Committee. We describe them briefly here and in more detail on starting on Page 221.

SIM Funded Projects

- **Care Management Dashboards:** SIM will provide Community Mental Health Centers (and will likely provide Community Health Teams) with dashboards that display real-time and historical information on hospital and ED utilization by their entire patient

populations. Powered by the HIE infrastructure, these dashboards can show the exact location and status of patients being seen in all of the acute care hospitals in the state, as well as trending information about the subscriber's patient panel. This enables immediate intervention by the patients' care team. Additionally, the Dashboards retain information on patients for six months to provide additional trending information to users. This project has already been approved by the SIM Steering Committee and will be completed by the end of 2017.

Potential Future SIM Projects

- **Advanced Directives Registry:** SIM may help implement a centralized registry for advanced directives and other end-of-life documents, such as the Medical Order for Life Sustaining Treatment (MOLST). We are currently exploring whether and how we can implement this as a feature of the CurrentCare consumer portal through a series of interagency (EOHHS and RIDOH) conceptual planning meetings with RIQI.
- **Shared Care Plan:** SIM is exploring the implementation of a central shared care plan system to help coordinate care plans for patients who frequent multiple care settings, and whether and how we can institute this as a feature of the CurrentCare consumer portal. This topic has come up as a need in various conversations about the Community Health Teams and Patient Engagement.
- **Patient Engagement Tools:** The patient engagement workgroup is working on identifying patient engagement strategies and tools to support our SIM goals. While we do not yet know what tools will be selected, it is likely that HIT that supports patient engagement will become part of our HIT Plan, at which point the HIT Specialist will help oversee project implementation and operations.

Technical Assistance for Providers

Making sure that the technology tools we are developed are adopted and used regularly are critical aspects in achieving our overall SIM goals. While the SIM HIT plan focuses on the adoption of the tools such as the APCD, Common Provider Directory and the Feedback System, the SIM team recognizes the need to provide technical assistance (TA) to providers and other users of the system in advance of their deployment so that providers can take full advantage of the new capacity.

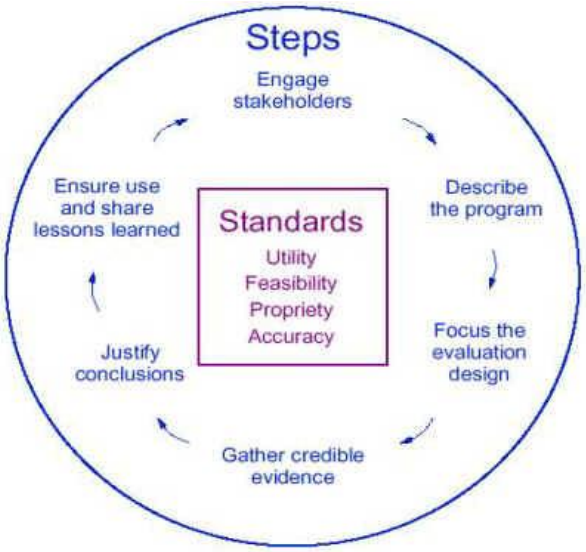
Given the numerous practice transformation activities that are under way in Rhode Island, we plan to leverage the Practice Transformation workgroup (described on Page 91) to ensure that the TA, the SIM team plans to leverage this group to identify what the TA we provide is effective and not duplicative. We will work with the vendors of the HIT systems to develop tools around the identified needs such as standardizing data collection in the EHR, use cases to demonstrate how data can best be analyzed, and training module for the systems. By working with the Practice Transformation Workgroup, we will be collaborating with CTC and TCPI to align training – and to determine if those entities can carry out the training alongside the work they are doing with practices. In this way, providers would be able to see how SIM's HIT Tools can address their data and care management needs in support of delivering high quality care under VBP systems. Finally, SIM will work with all of the state's HIT governance entities including the Reporting and Quality Measurement Feedback Workgroup, the Provider Directory Advisory Committee, the APCD Data Review Board, the HIT Advisory Commission, and the SIM Steering Committee to help identify TA needs and whether they are being met through existing programs.

Program Monitoring and Reporting

Program evaluation is fundamental to assess whether or not designed activities achieve the desired results once implementation begins. When conducting program evaluation, it is important to follow established methodologies, where applicable. For the Rhode Island State Innovation Model (SIM) Test Grant, the adapted framework within which program monitoring and reporting will occur is guided by the *Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health*. The six evaluation steps outlined by the CDC framework (noted below in Figure 13) include:

1. Engaging stakeholders;
2. Describing the program;
3. Focusing the evaluation design to set goals for what we are studying;
4. Gathering credible evidence;
5. Justifying conclusions; and
6. Ensuring use and sharing lessons learned.

Figure 58: Program Evaluation Steps



These six steps are embedded in a continuous process of improvement through program evaluation. These steps, while modified, are anchored as the fundamental components for Rhode Island SIM evaluation.

There are three parts to our SIM evaluation plan:

1) SIM leaders and staff will participate in the federal evaluation being undertaken by RTI. We expect three site visits, and regular monthly communications with the evaluation team.
2) SIM will retain professional outside evaluators to carry out a focused evaluation on the effectiveness of our project. We are in the process of preparing our procurement process for this vendor. They will be chosen through a competitive Request for Proposals (RFP). One particular part of this evaluation process is a project recently approved by our Steering Committee to document and compare the effects of Alternative Payment Models in use in the state. The purpose would be to learn how the models work, what related activities most support their success, and whether alignment of models across payers and providers would yield a greater impact on desired outcomes.
3) SIM will carry out regular in-house monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process.

As we procure and begin to work with our professional evaluator, we will determine the scopes of each of these efforts, to ensure that they are complementary but not duplicative. We know that we have information that we must report to CMS and CMMI, and our in-house evaluation work will be in service to those requirements. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

Evaluation Strategy and Plan

Step 1: Engage Stakeholders

Stakeholder engagement is the first step in the cyclical evaluation process. The persons who will be implementing or affected by the strategies defined are the stakeholders. Obtaining input from stakeholders in the development of this evaluation plan remains critical. Stakeholders also help to ensure that we are asking the right questions, collecting the right data, and using our evaluation results effectively.

Internal and external partners attend regularly scheduled workgroup and team meetings. Many partners are also involved in various academic and professional organizations. A smaller subgroup has been and will likely continue to be convened to vet measures selected as part of the Driver Diagram. An additional group will likely be formed as part of ongoing measurement needs for the Integrated Population Health Plan. These groups will continue to collaborate, prioritize, and/or develop evaluation questions and associated measurements. These groups will work together to determine feasible data sources, data collection methods, and indicators for our in-house tracking process. Over the course of the grant period, stakeholder engagement will be instrumental in redefining and focusing the scope of the evaluation, particularly as it relates to the resources available for ongoing evaluation and sustainment efforts.

In addition, we will be able to share these data sources and metrics with our professional evaluators and provide them with subject-matter experts for consultation.

Step 2: Describe the Program

SIM will be able to use the writing throughout this Operational Plan to describe our program to our evaluators and to stakeholders assisting with our monitoring.

Step 3: Focus the Evaluation Design

Designing an evaluation process that allows for making interim adjustments to programmatic direction, improving the way interventions are implemented, and providing iterative evidence to stakeholders on program success is critical. According to the Centers for Medicare and Medicaid Services (CMS), program evaluation for SIM must include regular, quantifiable measurement of model impact. Included in this in-house evaluation process are measures of effectiveness for policy change, regulatory lever use, and intervention implementation.

We will also work with our professional evaluators to help them plan the evaluation design.

A Defined Purpose
In an effort to focus efforts, we have the following primary purposes for our in-house evaluation:

- Assess planning efforts and collaboration among our strategic partners;
- Identify root causes for intervention successes and challenges related to both practice transformation, patient empowerment, and population health improvements;
- Detail efficiencies created by policy and regulatory changes; and
- Document the importance of increasing the capacity for supporting infrastructure such as workforce development and data availability; and
- Provide data-driven recommendations for sustainability beyond SIM.

Evaluation Questions
At least four overarching evaluation questions guide the evaluation of the SIM effort:

- To what extent has the Rhode Island SIM Test Grant strengthened population health?
- To what extent has the Rhode Island SIM Test Grant transformed the healthcare delivery system?
- To what extent has the Rhode Island SIM Test Grant decreased per capita healthcare spending?
- To what extent did the Rhode Island SIM Test Grant foster collaboration, align efforts across sectors and between partners, and increase data-driven decision-making?

As noted above, our Steering Committee is particularly interested in the question of best practices in the creation of value-based payment systems and alternative payment models. During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation, to participate in a mixed qualitative and quantitative research project. As a part of our process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

Proposed Learning Collaborative Participants:

- All payers (Medicaid, BCBSRI, UnitedHealthcare, NHPRI, Tufts Health Plan, Medicare)
- All provider participants in alternative payment models, including:
- Medicare Accountable Care Organizations (ACOs)
- Medicaid Accountable Entities (AEs)
- Medicare bundled payment demos
- Commercial payers' APMs

Proposed Research questions (to be asked at baseline and annually for three years):

- What alternative payment models (APMs) are in use?
- What population health management initiatives (practice changes/clinical management changes) have been prompted by, coupled with or supported by the APMs?
- What has been the effect of the payment models and related interventions on cost and quality?
- Is there value in more closely aligning or more broadly diffusing models across payers?
- If so, how could closer alignment and broader diffusion be achieved?

Quality Improvement and Procurement Reporting
While the data pertaining to the Driver Diagram and Integrated Population Health Plan will provide the basis for process, outcome, and balancing measures for which analysis will help in justifying SIM investments, we can gather additional evaluation data through the SIM procurement process and negotiated scopes of work with sub-recipients. Where applicable, collecting information and then reporting aggregate data using the CDC's framework for

"Mapping to a Series of Outcomes," will help Rhode Island quantify the success of interventions and identify potential root causes if sub-optimal results are achieved. To help assure all purposes of the evaluation are met, we will consider the following types of outcomes during reporting:

Table 28: Mapping to a Series of Outcomes

Outcome Type	Description
Participation	Measure of the number of people reached/engaging
Reactions	Measure of the degree of interest and passion for work
Learning	Measure of increased knowledge, skills, and understanding
Actions	Measure of behavioral patterns of change in a target group
System and Environment	Measure of changing social, economic, or environmental conditions
Health	Measure of contributions to health indicators

Step 4: Gather Credible Evidence

To support ongoing process and outcome evaluation, we are specifying metrics based on drivers and interventions presented within the Driver Diagram. CMMI requires states specify metrics in three areas:

- Model Participation
- Payer Participation
- Model Performance

To date, we have specified a suite of metrics for tracking implementation of SIM programs, such as Community Health Teams, SBIRT training, and clinical quality reporting and feedback, which align with CMMI's request for model participation metrics. We have also specified system transformation metrics that measure outcomes of the use of our regulatory levers, such as percent of medical service payments made under an alternative payment model, which align with CMMI's Payer Participating metrics. Rhode Island is committed to sharing all data relating with implementation of value-based payments in terms of dollars, covered lives, and provider participation, which we collect through existing regulatory initiatives.

We continue to engage stakeholders to specify model performance metrics, which seek to measure the outcome of our SIM project across domains of cost, quality, utilization, and population health. In the coming weeks SIM staff will be working with stakeholders through the Measure Alignment Work Group to develop model performance metrics, baselines and targets on measures such as hospital readmission rates, emergency department visits, diabetes care, behavioral health, and total cost of care. A full matrix describing all metrics is in development and will be updated along with the Driver Diagram prior to June 30, 2016.

Data Collection

We will be using several data collection methods, including both qualitative and quantitative methods, for our SIM evaluation. Using multiple procedures for gathering, analyzing, and interpreting data, the evaluation will gain greater credibility and provide a clearer picture of the program. We will make modifications as needed to account for the evolving nature of the program. Additional detail on data collection can be found in the Data Collection, Sharing, and Evaluation section of this document. All quality and cost measures will use the entire Rhode Island population as the denominator. Where applicable, we will also collect and analyze demographics and disparity data–and we will share our data with our professional evaluator.

Step 5: Justify Conclusions

Evaluation will be a critical component of all of our efforts–both in-house and professionally. To incorporate evaluation across SIM investments and activities, we will maximize the following to provide additional data upon which conclusions can be drawn:

- All procurement via Request for Proposals or Single Source Procurements will include requirements for developing activity objectives, logic models, and evaluation plans;
- All procurement via Request for Proposals or Single Source Procurements will include requirements to report performance data relative to activity objectives regularly and alongside annual reports;
- Vendors will submit regular progress reports to Project Management and Project Officer staff;
- Cross-cutting interventions, such as those being implemented for workforce development and health information technology, will include requirements for evaluation information in a variety of ways, including case studies, lessons learned, and metrics.
- We will bring together the vendors for shared learning opportunities, to collaborate across separate transformation activities.
- We will ensure that our professional evaluators have access to all of this information to inform their work.

Step 6: Ensure Use and Share Lessons Learned

SIM leaders and staff are committed to using the evaluation information described throughout this document to measure our successes, identify and address our challenges, and chart new paths for changing our healthcare system. The public nature of SIM ensures that we will share evaluation information with our agency partners, our Steering Committee stakeholders, and the general public at our regular meetings and at other special opportunities. We will create a specific communications plan for sharing this information.

Data Collection, Sharing, and Evaluation

Rhode Island will require regular data about cost, quality, and utilization to fully understand the impact of the SIM Test Grant initiatives. Some existing data sources for these information are available. Since Rhode Island's SIM Test Grant is a statewide initiative, we will measure outcomes across the state as a whole, and compare the majority of outcomes against those of other (non-SIM) states. There are five major datasets where health indicators data are or will be collected for sharing and evaluation in Rhode Island and will be leveraged for our SIM project:

- HealthFacts RI
- Medicaid
- RIDOH Center for Health Data and Analysis (CHDA) Data Sources
- HealthSource RI Qualified Health Plan Enrollee Survey
- Electronic Clinical Quality Measurement, Reporting, and Feedback System
- State Data Ecosystem and EOHHS Data Warehouse

The Executive Office of Health and Human Services (EOHHS) is one unified legal entity, meaning that no data sharing agreements are required between different Departments that make up the office (including Medicaid, RIDOH, and DCYF). Data use involving protected health information would be limited to appropriate uses under HIPAA and state privacy laws.

For data sharing with agencies outside of EOHHS, we will work with those agencies to put the necessary data sharing agreements in place that will support us achieving our SIM Goals. We will be determining which external data sources will be needed and creating a plan to gain access to that data in Year 2. Also we acknowledge that one part of meeting our SIM goals, especially within our Integration & Alignment Project, may be our need to share data more broadly with outside agencies, and will include this concept in our strategies for data sharing and collection.

HealthFacts RI

Claims data from payers with at least 3,000 enrolled members is submitted quarterly to HealthFacts RI, the SIM Test Grant-funded all payer claims database. This include CMS provided Medicare Part A, B, and D claims data, private insurance (including Medicare Advantage plans), and Medicaid data. Claims data will be used to understand the cost of care provided in value-based payment arrangements, as well as some key indicators of utilization and quality that are available in claims data.

Although de-identified, patient data in HealthFacts RI does carry a unique patient identifier which will allow for an identifier to be assigned when patients are covered by the SIM program activities for tracking and evaluation purposes. The metrics which will be measured using HealthFacts RI are indicated in the metrics section of this document.

We prioritize HealthFacts RI's careful privacy protections and procedures. Although de-identified, there is still enough information in HealthFacts RI to potentially identify a participant. Therefore HealthFacts RI data releases are governed by the Data Release Review Board (DRRB) – an 11-member advisory board to the Director of Health. Some data can be released in aggregate form without review by the DRRB, but anything which is claim line level or does not conform to pre-approved files may require a data release application. Rhode Island staff will assist CMS and/or its contractors in navigating the state legislated data release process, should it be necessary, and waive any standard fees for data. The HealthFacts RI analytics vendor is responsible for providing data extracts for partners, including file specifications.

Medicaid

Our Medicaid agency is also supplying detailed Medicaid member information by request to CMS and federal evaluators as needed for surveys, focus groups, and/or key informant interviews. Medicaid is dedicated to measuring and understanding the impact of the state's initiatives to improve care, and will facilitate all appropriate data sharing in compliance with state and federal laws.

We have already shared the data required by our RTI evaluators for their recent site visit to Rhode Island (May 23-25, 2016), including Medicaid members and behavioral health providers. We now have the process set up to continue to share data with RTI as necessary, including access to the appropriate, secure data-sharing technology.

Center for Health Data and Analysis (CHDA) Data Sources

There are numerous surveillance systems, databases, and measurement sources that serve as primary information sources and collection methods at RIDOH. Information once collected, is analyzed on a program-specific level, and at times, by the Center for Health Data and Analysis (CHDA) for the production of data briefs and a variety of other dissemination documents. Sharing of data is initiated by data requests, media inquiries, and publication needs. Shared data abides by the Department's policy for dissemination of data. Typical modes of distribution include infographics and posters, stakeholder meetings and conferences, publications, on websites, and in the form of data briefs/books. File sharing can be requested between agencies and requires a Memorandum of Agreement.

Behavioral Risk Factor Surveillance System (BRFSS)

The Rhode Island Department of Health (RIDOH) collects data for a variety of surveillance systems, databases, and measurement sources. For population health, the Behavioral Risk Factor Surveillance System (RI BRFSS) is a primary collection method. The RI BRFSS is a multi-modal landline and cell-phone survey that represents a sample of Rhode Island residents. The survey is conducted in monthly replicates, for which information covering health-related behaviors, chronic conditions and preventive health practices is collected from respondents ages 18 and older. Rhode Island has participated in the BRFSS since 1984, with financial and technical support provided through a cooperative agreement with the CDC and from additional funding received from various RIDOH sources.

The RI BRFSS is performed to specifications provided by CDC to the 50 states and seven territories that participate in the surveillance system. Prior surveys have been a key source of data for supporting public health programs and health-related legislation within Rhode Island. In addition, RI BRFSS data has been used for assessing Rhode Island's improvement in key health risk behaviors. The RI BRFSS is also one of the sources for key indicator data used in Healthy Rhode Islanders 2020 and by numerous RIDOH programs. Information provided by the RI BRFSS is not available from other sources within the State and as part of a nationwide surveillance system, the BRFSS provides comparisons with other states and the nation.

RI BRFSS data and measures will likely be used to look at overall health burdens in Rhode Island as well as disease-specific assessment and prevalence data, as applicable. When looking for population-level self-report data for elements such as cost barriers associated with getting medical care, RI BRFSS will likely be a primary source of information. For more information about specific measure selection for population health, please read the SIM Integrated Population Health Plan.

Table 29: Summary Table of CHDA Data Sources

Data Set Name	Data Set Description	Collection Period and Methods	Data Availability
Rhode Island Special Needs Emergency Registry	The public can enroll in this registry if they think they will need assistance from local first responders in an emergency. Fields collected are: name, data of birth, address, phone, cell, email, ethnicity, race, language, mobility issues, life sustaining equipment use, sensory, cognitive or behavioral issues, as well as emergency contact name and phone.	Ongoing. Anyone can enroll at any time online	Aggregate data is available to the public. Local first responders have access to the data for their municipality only.
Hospital Discharge Data (HDD)	When a patient is discharged from an Inpatient stay in a Rhode Island hospital, the hospital is mandated to report the patient's information to the Center for Health Data & Analysis at the Department of Health.	Quarterly. Most recent - October 1, 2013 to December 31, 2013. Data are extracted from hospital billing systems, non-billing items are added, and the data are submitted to the Center for Health Data and Analysis, either directly or through a contracted data processor.	Available on request. Data available approximately 6 months after the end of each calendar quarter.
Emergency Department Data	When a patient is discharged from an Emergency Department visit at the ER in a Rhode Island hospital, the hospital is mandated to report the patient's information to the Center for Health Data & Analysis at the Department of Health. Patients whose visit resulted in an Admission are not included in this data set but are included in the Hospital Inpatient data set.	Quarterly. Most recent - October 1, 2013 to December 31, 2013. Data are extracted from hospital billing systems, non-billing items are added, and the data are submitted to the Center for Health Data and Analysis, either directly or through a contracted data processor.	Available on request. Approximately 6 months after the end of each calendar quarter.
Behavioral Risk Factor Surveillance System (BRFSS)	The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based computer-assisted telephone interview survey. The collection process uses uniform guidelines and a standard questionnaire. In collaboration with other state health departments, the Centers for Disease Control and Prevention, and other department programs, a survey instrument is developed. The survey is administered as a random-digit dial telephone survey of non-institutionalized people age 18 or older. Information on health status, health risk behaviors, preventive practices, healthcare access, and prevalence of	Collected since 1984. Most recent data available 2012. Collected on an ongoing basis by telephone interviews (random digit dial landline and cell phones) conducted by a contractor selected by competitive bid.	Available on request. Data are available in June for the prior year's data collection.

	chronic conditions is collected and analyzed.		
Birth Defects Surveillance	Registry of children with Rhode Island maternal residence who are less than five years old and diagnosed with a birth defect.	Ongoing. Most recent data available- 3/1/2014	Partial data available on request.
Pregnancy Risk Assessment Monitoring System (PRAMS)	Pregnancy Risk Assessment Monitoring System (PRAMS) was initiated in 1987 as part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. In recent years, the program has been expanded in support of CDC's Safe Motherhood Initiative to promote healthy pregnancies and the delivery of healthy infants. PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child's early infancy among a stratified sample of women delivering a live birth.	Monthly. Last completed year of data collection is 2012. Last completed weighted data set available is 2011.	Available on request.
Violent Death Reporting System	Violent death surveillance with data collected from multiple sources. Uses data from medical examiner files, law enforcement reports, vital records, and others on deaths due to homicide, suicide, deaths of undetermined manner, and unintentional firearms deaths. Funding is from CDC.	Ongoing data collection	Partial and aggregate data available on request. Also available on CDC WISQARS http://www.cdc.gov/injury/wisqars/index.html
Youth Risk Behavior Survey (YRBS)	To assess health-risk behaviors in public school students grades 6 through 12 that contribute to the major causes of death, disease, injury, and social problems.	Biennially (odd years). Data is available bout 4-5 months after data collection is completed.	Available on request.
KIDSNET	KIDSNET is a population based integrated child health information system that facilitates the collection and appropriate sharing of preventive health services data for the provision of timely and appropriate follow-up. KIDSNET serves as Rhode Island's childhood immunization registry for children up to age 19 and links data from ten different public health programs (newborn bloodspot, hearing and developmental screening, vital records, home visiting, immunization, lead screening, WIC, Early Intervention and	Ongoing. Data collection begins at birth with the electronic birth certificate and a chart review for developmental risk factors. Program data is submitted electronically from 8 participating childhood public health programs as infants and children receive these services. Home visiting and some immunization data are entered manually.	Aggregate data available.

	Asthma) as well as having indirect connections with birth defects and foster care data.		
School Immunization Assessment	Each year, RI Kindergarten and 7th grade students aggregated immunization status data are reported by school nurses.	Yearly. Most recent data available 2012-2013 school year.	Available on request
Maternal and Child Health Data	To determine maternal and child health needs of Rhode Islanders and assess health status and well- being of children and families.	Dependent on availability of vital statistics data. As each new year of vital records data become available, they are added to the database.	Available on request.
Cancer Screening and Tracking system (CaST)	Information for women eligible to participate in the RI Women's Cancer Screening Program (WCSP). For women eligible to participate in the WCSP: demographic information, dates and results of screening tests for breast cancer (mammograms & clinical breast exams) and cervical cancer (Pap tests or Pap & HPV co-tests). For women with abnormal screening results: dates and results of breast and cervical cancer diagnostic tests including final diagnosis, date of final diagnosis, date treatment was started, and cases of breast and cervical cancer found and matched to cases in the RI Cancer Registry.	Ongoing data collection since 1985.	Aggregate data available
Lead Elimination Surveillance System	Blood lead data for children and adults.	Ongoing.	Raw data, partial and aggregate available.
Asbestos Plan Management Data	Tracks submission of asbestos plans.	Ongoing.	Aggregate data available
3RNET	Tracks the name and specialties of doctors who want to obtain employment in the state of RI	Bi-monthly. Most recent data available - February - March, 2014.	Raw data available on request
Home Visiting Data	To provide quality assurance for the Health Department's Family Outreach Program, which provides home visits to infants/children identified as "at-risk" at the time of birth.	Following each home visit, a data form is completed by each visiting nurse agency regarding the content of the visit.	Available on request

Universal Newborn Developmental Risk Screening	All infants born in Rhode Island are screened for developmental risk factors in order to determine appropriate service provisions and referral in accordance with section 7.1 of RI General Law R-23-13-22 (Pertaining to the provision of Early Intervention Services for Infants and Toddlers with Disabilities and Their Families). This also helps fulfill federal requirements under the Individuals with Disabilities Education Act (IDEA), 34 CFR Part 303 (Part C).	Data are available for analysis on a current basis. Reports are generated on quarterly and ad hoc basis. Within 24-48 hours following birth, nurse coordinators contracted by RIDOH abstract information from medical records and birth certificate worksheets for demographic and birth outcome information in order to determine risk status of the newborn. These data are then sent electronically to RIDOH.	Available on request
Women Infant and Children Food Supplement Program (WIC)	To collect data on WIC participants for assessment, assurance and policy development.	Monthly. Data are collected by the WIC clinics and entered into the WIC data system.	Available on request
Beaches Monitoring Data	Beach water quality monitoring, notification, and locational data.	Ongoing. Most recent data available- 3/1/2014	Raw data available on request
License2000	The License2000 database contains all of the licensing data for the Department of Health (excluding Office of Managed Care). It is the source for license issue date, expiration date, fees owed and paid, licensee demographics, education information, and contact information.	Ongoing.	Raw data available on request
Health Facility File	Demographics for all licensed health care agencies/facilities. Licensed health care entities including for name, address, ownership, phone, fax, contact, bed capacities, etc.	Collected at time of initial licensure and end of year renewal (every one of two years depending upon license type)	Aggregate downloaded from L2K web site
Minimum Dataset for Nursing Facilities	Nursing Home resident assessment data. A comprehensive assessment of each resident's functional capacity and health status. Assessment variables include identification information, hearing/speech/vision, cognitive functioning, emotional state, behavior, preferences for customary routine and activities, functional status, bladder and bowel functioning, health conditions, swallowing/nutritional status,, oral/dental status, skin conditions, medications, special treatments/procedures and programs, restraints, participation	Resident assessment data are collected by long term care facilities upon admission, discharge, transfer, quarterly and/or upon significant change in resident status. Most recent data available 2011-2014	Aggregate data available

	in assessment and goal setting and discharge/care planning.		
Targeted Community Outreach Database	Division of Infectious Disease & Epidemiology is funded through the CDCs Category C demonstration project to evaluate projects designed to link and retain HIV+ individuals in care. 5 RI agencies are funded to conduct targeted community outreach to find and test hard to reach populations for HIV.	Monthly. Data submitted on the 10th of each month.	Available on request.
National Electronic Disease Surveillance System (NEDSS)	The NEDSS "dataset" is comprised of stored patient, disease-specific, and laboratory data that are manually entered or received electronically. In addition, users are able to enter in vaccination records (via chart reviews but mostly KIDSNET lookup).	Ongoing, collected on a daily basis.	Aggregate data available
Enhanced HIV/AIDS Reporting System (eHARS)	Application for collecting, storing, and retrieving the data the CDC has identified as necessary to: (1) monitor the HIV/AIDS epidemic, (2) evaluate HIV prevention policies and programs. Typical data stored in eHARS include HIV laboratory results, CD4 lab results, Viral Load lab results, HIV/AIDS case report form data.	Data is reported from facilities in an ongoing manner.	Aggregate data available
Cancer Registry	To collect limited information on all newly diagnosed cases of cancer and on all newly diagnosed benign tumors of the brain and central nervous system in Rhode Island.	Ongoing. Data is collected primarily by electronic case report from health care facilities. Facilities are required to report cases within 180 days of diagnosis.	Aggregate data available
Death Records	RIGL 23-3-16 requires registration of all death records, from which data are derived. The data set covers all persons who die in Rhode Island and all Rhode Island residents who die out-of-state.	Ongoing. Data collected since 1983. Most recent-January 2014. Funeral Directors are responsible for collecting the personal information and for obtaining the cause of death from the physician.	De-identified, partial dataset available by request. Preliminary data on deaths occurring in Rhode Island are available within one year after the end of the calendar year. Final data, including out-of-state deaths of Rhode Island residents, are available no sooner than 2 years after the end of the calendar year.

Birth Records	RIGL 23-3-10 requires registration of all birth records, from which data are derived. The data set covers all child born in the state of Rhode Island or a child born out-of-state to a Rhode Island resident.	Ongoing. Data collected since 1982. Most recent -March 2014. Data are collected from the seven RI birthing hospitals, office of vital records for home births and any of the 57 reporting jurisdictions within the USA where a RI resident had a birth.	De-identified, partial dataset available on request. Preliminary data on births occurring in Rhode Island are available within one year after the end of the calendar year, including out-of-state births to RI residents. Final data are available no sooner than 2 years after the end of the calendar year.
Fetal Death Records	RIGL 23-3-10 requires registration of spontaneous fetal death records and reports of induced fetal deaths. Data are derived from these records and reports. Data set covers all fetal deaths (spontaneous or induced), which occurs in the State of Rhode Island.	Ongoing. Data collected since 1985. Most recent -December 2013. Data are provided by Institutions and Funeral Directors.	De-identified, partial dataset available on request. Preliminary data on fetal deaths occurring in Rhode Island are available within one year after the end of the calendar year. Final data are available no sooner than 2 years after the end of the calendar year

HealthSource RI Qualified Health Plan Enrollee Survey

In order to holistically evaluate the effectiveness our work, it is essential to collect and evaluate not only outcomes data but also information on customer perception and experience. As the health insurance exchange for the state, HealthSource RI (HSRI) has worked with carriers participating in the Marketplace to evaluate consumer experience with enrollment and insurance plan utilization. Developed by CMS and administered via an approved survey vendor, the Qualified Health Plan (QHP) Enrollee Survey was Beta tested in the first half of 2015 and will be fully implemented nationwide in 2016. The QHP Enrollee Survey will evaluate nine areas of plan enrollment and use including: access to care, access to information, care coordination, cultural competence, plan administration, rating of health care, rating of health plan, rating of personal doctor, and rating of specialist. The survey results will be made publicly available in fall 2016 to consumers, carriers, and state exchange's in an effort to drive evidence-based decision making in plan development and to provide additional information to consumers to aid in plan selection. Information gathered from the QHP Enrollee Survey, as well as enrollment and claims data will enhance HSRI's effort to address the health insurance needs of Rhode Island consumers. This information will also be used to assist in the development of innovative plans offered through the exchange.

Healthcare Quality Measurement, Reporting, and Feedback System

This SIM Test Grant funds an electronic clinical measurement reporting and feedback system which will begin to collect more detailed clinical data across a broader population of consumers in Rhode Island. It is unlikely that this system will be adequate to measure outcomes across the state by the end of project period or confidently provide a historical understanding of clinical quality. We recognize that clinical quality data on our population is relatively sparse and inconsistent, a weakness which will be strengthened for future evaluation activities with this new data system.

Social and Environmental Determinants of Health Measurement

RIDOH has convened an internal and external Community Health Assessment Group (CHAG) to development measures of health equity for Rhode Island, using local data systems. In addition, the CHAG, as a group of evaluation experts, is working to determine a common evaluation and health equity indicators for specifically for the HEZ and other healthy equity

work being done by RIDOH. The Rhode Island SIM Chief Heath Program Evaluator has been invited to be a participant on both the internal and external groups to ensure integration with SIM and maximize incorporation of new measures through this bi-directional alignment approach. This group will build on the progress being made on the national level through recent reports from the Institute of Medicine.

Evaluation

We are committed to supporting any evaluation efforts taking place within our SIM Test Grant. This spans from the federal evaluation team contracted by CMS to individual evaluation teams within our SIM Components. To date we have supplied data to the evaluators whenever requested and will continue to do so throughout the duration of our SIM Test Grant, including any file specifications or other support materials.

Additionally, OHIC will leverage regulations in place that allow it to request data from payers specifically to support the SIM Test Grant, in order to ensure the data used in the evaluation efforts is comprehensive and will accurately describe the impact of our activities in Rhode Island.

Fraud and Abuse Prevention, Detection, and Correction

The State Office of Program Integrity (OPI) ensures compliance, efficiency, and accountability within the health and human services programs administered by the Executive Office of Health and Human Services (EOHHS) by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.

The OPI has developed protocols and procedures to detect and deter fraud, waste and abuse. The OPI is focusing on all publically funded health and human services programs, not just Supplemental Nutrition Assistance Program (SNAP) and Medicaid, using sophisticated data mining and modeling techniques to identify unusual patterns of purchasing and billing by third parties.

The guiding principles of the OPI are that it:

1. Strives to achieve the most cost efficient health care system possible while further enhancing the quality and appropriateness of services delivered.
2. Requires and supports efforts that enable health care providers to identify and resolve issues themselves.
3. Holds provider agencies accountable for building and maintaining systems to prevent improper billing.
4. Increases the usage of the administrative tools such as payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered.
5. Develops and communicates consistent measures of the effectiveness of program integrity that capture cost reduction and avoidance, as well as recoveries, and minimize costs imposed by reviews and investigation.
6. Recognizes areas of vulnerabilities that adversely affect program integrity.

The Office of Program Integrity is committed to identifying fraud, waste and abuse in Medicaid and in all health and human service programs. The OPI utilizes advanced analytics software that assigns scores to claims for potential healthcare fraud. This scoring looks for duplicate claims, individuals with multiple member ids, suspicious provider network activity, peer comparison for both providers and members, and predictive analytics that identify scenarios where activities should have happened that did not. The resulting scoring is displayed in an advanced visual interface to allow investigators to review and assess the results of the analysis.

The OPI actively pursues any leads indicating fraudulent practices and uses them as a source to begin investigations. To increase our effectiveness, the OPI is partnering with Medicare and Medicaid insurance companies to share information about fraudulent activity and to conduct joint investigations.

The OPI also receives complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Office staff triage and investigate every valid complaint.

Decisions rendered by the review process can result in refunds to the program for inappropriate payments, training on how to correct or improve billing practices, referral to licensing boards,

and/or referral to the RI EOHHS Office of Program Integrity and the RI Office of the Attorney General for suspected fraudulent practices.

The Office of the Attorney General's Medicaid Fraud and Patient Abuse Unit enforces the laws pertaining to fraud in the state Medicaid program and prosecutes cases of abuse, neglect, or mistreatment of patients in all state healthcare facilities. The Unit prosecutes criminal activity, pursues civil remedies where appropriate and participates with federal and state authorities in a variety of inter-agency investigations and administrative proceedings. Unit prosecutors, auditors, investigators and health care professionals employ a multi-disciplinary approach to combat health care fraud and patient abuse.

Acronym and Abbreviation List

The following is a list of acronyms and abbreviations used in the Project Summary for the Operational Plan. For definitions of terms, see the Glossary of Terms section of the Appendices document.

Acronym	Meaning
ACA	Affordable Care Act
ACC	Accountable Care Community
ACE	Adverse Childhood Event
ACO	Accountable Care Organization
ACS-CDC	American College of Surgeons – Centers for Disease Control and Prevention
AE	Accountable Entities
AE-C	Certified Asthma Educator
AHC	Accountable Healthcare Communities
AMQ	Adult Medicaid Quality Grant
APCD	All Payer Claims Database (HealthFacts RI)
APM	Alternative Payment Model
ARC	Asthma Regional Council
BCBSRI	Blue Cross & Blue Shield of Rhode Island
BH	Behavioral health
BHDDH	Department of Behavioral Health, Developmental Disabilities, and Hospitals
BHOLD	Behavioral Health On-Line Data
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CABHI	Collaborative Agreement to Benefit Homeless Individuals
CAHPS	Consumer Assessment of Hospital and Provider Services
CAPTA	Child Abuse and Prevention Treatment Act
CAUTI	Catheter Associated Urinary Tract Infection
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CDOE	Certified Diabetes Outpatient Educators
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation
CEHRT	Certified Electronic Health Record Technology
CHAG	Community Health Assessment Group
CHH	CEDARR Health Home
CHIP	Children's Health Insurance Program
CHN	Community Health Network
CHNA	Community Health Needs Assessment
CHT	Community Health Team
CHW	Community Health Worker

Acronym	Meaning
CLABSI	Central Line Associated Blood Stream Infection
CMHC	Community Mental Health Center
CMHO	Community Mental Health Organization
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease
CS4RI	Computer Science for Rhode Island
CSC	Coordinated Special Care
CTC	Care Transformation Collaborative
CTTS	Certified Tobacco Treatment Specialist
CVDOE	Cardiovascular Disease Outpatient Educator
DCYF	Department of Children, Youth and Families
DEA	Division of Elderly Affairs
DEA Number	Drug Enforcement Administration Number
DEI	Disability Employment Initiative
DHS	Department of Human Services
DLT	Department of Labor and Training
DOA	Department of Administration
DOC	Department of Corrections
DOE	Department of Education
DRRB	Data Release Review Board
EBP	Evidence Based Practice
ED	Emergency Department
EHR	Electronic Health Record
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act
FAD	Financial Alignment Demonstration
FQHC	Federally Qualified Health Center
GDP	Gross Domestic Product
HARI	Hospital Association of Rhode Island
HARP	Home Asthma Response Program
HbA1c	Hemoglobin A1c
HCPAAC	Health Care Planning and Accountability Advisory Council
HEZ	Health Equity Zone
HH	Health Home
HIE	Health Information Exchange
HIT	Health Information Technology
HOPWA	Housing Opportunities for Persons with AIDS Program
HPD	Healthcare Provider Directory

Acronym	Meaning
HPSA	Health Professional Shortage Area
HPV	Human Papillomavirus
HRiA	Health Resources in Action
HSRI	HealthSource RI
HUD	U.S. Department of Housing and Urban Development
IBH	Integrated Behavioral Health
ICI	Integrated Care Initiative
IDD	Intellectual and Developmental Disabilities
IHD	Ischemic Heart Disease
IHH	Integrated Health Home
IP	Inpatient
IPHP	Integrated Population Health Plan
IPS	Induvial Placement and Support
LAN	Learning and Action Network
LE	Life Expectancy
LMI	Labor Market Information
LTPAC	Long Term and Post Acute Care
LTSS	Long-Term Services and Supports
MAPCP	Multi-Payer Advanced Primary Care Practice
MCO	Managed Care Organizations
MFP	Money Follows the Person
MHPSA	Mental Health Professional Shortage Area
MMCO	Medicaid Managed Care Organization
MOLST	Medical Orders for Life Sustaining Treatment
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCQA	National Committee for Quality Assurance
NEAIC	New England Asthma Innovation Collaborative
NHPRI	Neighborhood Health Plan Rhode Island
NHSC	National Health Service Corp
NICU	Neonatal Intensive Care Unit
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NQF	National Quality Forum
OHIC	Office of the Health Insurance Commissioner
ONC	Office of the National Coordinator
OPI	Office of Program Integrity
PATH	Project Assistance in Transition from Homelessness
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDAC	Provider Directory Advisory Committee
PDMP	Prescription Drug Monitoring Program
PMPM	Per Member Per Month

Acronym	Meaning
PQRS	Physician Quality Reporting System
PRAMS	Pregnancy Risk Assessment Monitoring System
ProvPlan	Providence Plan
PSH	Permanent Supportive Housing
PY	Program Year
QCDR	Qualified Clinical Data Registry
QHP	Qualified Health Plan
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
RFP	Request for Proposal
RHIO	Regional Health Information Exchange Organization
RICCC	Rhode Island Chronic Care Collaborative
RIDE	Rhode Island Department of Education
RIDOH	Rhode Island Department of Health
RIHTP	Rhode Island Health Transformation Program
RIMS	Rhode Island Medical Society
RIPCPC	Rhode Island Primary Care Physicians Corporation
RIQI	Rhode Island Quality Institute
RTI	Response to Intervention
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
SE	Supported Employment
SED	Serious Emotional Disturbance
SHIP	State Health Innovation Plan
SIM	State Innovation Model Test Grant
SMI	Severely Mentally Ill
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNFRM	Skilled Nursing Facility Readmission
SPA	State Plan Amendment
SPF-PFS	Strategic Prevention Framework – Partnership for Success
SPMI	Severely and Persistently Mentally Ill or Serious and Persistent Mental Illness
SSI	Surgical Site Infection or Supplemental Security Income
SSI/SDI	Supplemental Security Income/ Supplemental Disability Income
STARS	Standardized Tobacco Assessment for Retail Settings
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAC	Technical Assistance Collaborative
TANF	Temporary Assistance for Needy Families
TCPI	Transforming Clinical Practice Initiative

Acronym	Meaning
UHIP	Unified Health Infrastructure Project
UMASS	University of Massachusetts Medical School
UMID	Unified Multi-Purpose ID
VBP	Value-Based Payment or Value-Based Purchasing
WIA	Workforce Investment Act
WIC	Women Infants Children
W-P	Wagner-Peyser Act
YRBSS	Youth Risk Behavior Surveillance System

Appendices Begin Here

Appendix 1: Metrics Details

Metric Title	Data Source	Reporting Frequency	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Insured Claims Trend (PMPY)	HealthFacts RI	Annual	Percentage change in medical claims PMPY across all lines of business (Commercial, Medicare, Medicaid)	2%	Claims Cost	Member months	Statewide Insured Population	Outcome	Percentage Change	Cost	N/A	3.5% represents the long-term average rate of growth in gross state product.	<= 3.5%	<= 3.5%	<= 3.5%	<= 3.5%
30 Day All Cause Readmissions	HealthFacts RI	Annual	Percentage of index admissions that were readmitted for any cause within 30 days of discharge	TBD	Readmissions within 30 days	Index admissions	Statewide Insured Population	Outcome	Percent	Utilization	N/A	We will determine whether to use the 3M methodology or an alternative within the next 3 months.	TBD by August 2016	TBD by August 2016	TBD by August 2016	TBD by August 2016
ED Visits per 1,000 members	HealthFacts RI	Annual	ED Visits per 1,000 members	TBD	ED visits	Member months	Statewide Insured Population	Outcome	Normalized Count	Utilization	N/A	None	TBD by August 2016	TBD by August 2016	TBD by August 2016	TBD by August 2016
Payments made under alternative payment models (Commerical Insurers) - APM Categories 3 + 4	OHIC	Annual	Percentage of fully insured commercial medical payments made under an alternative payment model (APM)	24% (2014)	Payments associated with APM Categories 3 + 4	Total payments	Payments - Fully insured commercial	Structure	Percentage	Performance	N/A	None	30%	40%	50%	50%

Members attributed to total cost of care alternative payment models (Commerical Insurers) - APM Categories 3 + 4	OHIC	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.	20% (2014)	Health plan members attributed	Total health plan members	Insured members - Fully insured commercial	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	30%	40%	50%	50%
Payments made under Value-based payment models (Commercial Insurers) - APM Categories 2 +3 + 4	OHIC	Annual	Percentage of fully insured medical payments tied to value	≈50%	Payments associated with APM Categories 2 + 3 + 4	Total payments	Payments - Fully insured commercial	Structure	Percentage	Performance	N/A	None	50%	65%	80%	80%
Payments made under alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments made under and APM	0% (2014)	Payments associated with APM Categories 3 + 4	Total payments	Payments - Medicaid Managed Care	Structure	Percentage	Performance	N/A	None	TBD by August 2016	TBD by August 2016	50%	50%
Members attributed to total cost of care alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.	0% (2014)	Health plan members attributed	Total health plan members	Insured members - Medicaid Managed Care	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	0%	25%	35%	50%
Use of Value-based payment models (Medicaid MCOs) - APM Categories 2 +3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments tied to value	0% (2014)	Payments associated with APM Categories 2 + 3 + 4	Total payments	Payments - Medicaid Managed Care	Structure	Percentage	Performance	N/A	None	TBD by August 2016	TBD by August 2016	80%	80%
PCPs participating in ACOs	OHIC	Annual	% of network PCPs participating in ACOs and who are attributed patients for whom they are assuming clinical and financial accountability	TBD	Network PCPs participating in ACO	Network PCPs	Providers	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	TBD by August 2016	TBD by August 2016	TBD by August 2016	TBD by August

																2016
PCPs practicing in PCMHs	OHIC	Annual	% of network PCPs practicing in PCMHs	50%	Network PCPs practicing in PCMH	Network PCPs	Providers	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	60%	70%	80%	80%
Commercial members attributed to PCMHs	OHIC	Annual	% of commercial insured members attributed to a PCMH	TBD	Health plan members attributed	Total health plan members	Insured members - Fully insured commercial	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	TBD by August 2016	TBD by August 2016	TBD by August 2016	TBD by August 2016
Medicaid members attributed to PCMHs	EOHHS	Annual	% of Medicaid MCO members attributed to a PCMH	TBD	Health plan members attributed	Total health plan members	Insured members - Medicaid Managed Care	Structure	Percentage	Performance	N/A	System Transformation Tracking Measure	TBD by August 2016	TBD by August 2016	TBD by August 2016	TBD by August 2016
New Teams: Team Expansion	EOHHS	Quarterly	Number of active SIM-funded CHTs	0	Number of teams	N/A	Providers	Structure	Count	Performance	N/A	None	2	2	2	2
New Teams: Operating Capacity	CHT Vendor	Quarterly	Percent of new, SIM-funded CHTs actively seeing patients in Rhode Island	0	New teams seeing patients	Total new teams funded	Providers	Structure	Percentage	Performance	N/A	None	100 %	100 %	100 %	100 %
New Teams: Practice Expansion	CHT Vendor	Quarterly	Number of unique practices utilizing new, SIM-funded CHTs	0	Number of practices utilizing CHTs	N/A	Providers	Structure	Count	Utilization	N/A	*Target contingent upon geographic coverage area and size of engaged practice(s)	5-10*	5-10*	5-10*	5-10*
Consolidated Operations: Participation	CHT Vendor	Quarterly	Number of CHTs participating in the statewide CHT consolidated operations model	0	Number of CHTs participating	N/A	Providers	Process	Count	Utilization	N/A	*General goal aside from SIM is to have more CHTs in RI and Consolidated Operations would be made available to any CHT	2	4*	4*	4*

Consolidated Operations: Data Reporting	CHT Vendor	Quarterly	Percentage of completed data reports submitted by consolidated operations team	0	Number of completed data reports submitted	Number of data report requests	Providers	Process	Percentage	Performance	N/A	None	100%	100%	100%	100%
Current Team Enhancements: Provider Training	CHT Vendor	Quarterly	Number of provider trainings delivered about practice transformation and CHT benefits	0	Number of provider trainings delivered	N/A	Providers	Process	Count	Utilization	N/A	*Target will change based on need	10	30	50	50
Current Team Enhancements: Tools/Assessments	CHT Vendor	Quarterly	Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients	0	Number of tools and assessments adopted	Number of tools and assessments available	Providers	Process	Percentage	Performance	N/A	*Target may change due to cost of identified tools/assessments	TBD	TBD	TBD	TBD
Overarching, Collective Impact: Service Delivery	CHT Vendor	Quarterly	Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)	0	Number of patients who received services	Number of patients referred	Patient Group	Process	Percentage	Performance	N/A	None	100%	100%	100%	100%
Overarching, Collective Impact: Care Coordination	CHT Vendor	Quarterly	Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare	0	Number of CHT patients who enrolled in CurrentCare	Number of patients seen by CHTs	Patient Group	Outcome	Percentage	Performance	N/A	None	100%	100%	100%	100%
Overarching, Collective Impact: Prevention	CHT Vendor	Quarterly	Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination	0	Number of CHT patients who received annual influenza vaccine	Number of patients seen by CHTs	Patient Group	Outcome	Percentage	Clinical	N/A	None	100%	100%	100%	100%
Overarching, Collective Impact: Workforce Capacity	RICB	Annually	Number of Community Health Workers certified through the Rhode Island Certification Board	0	Number of Certified Community Health Workers	N/A	Providers	Balance	Count	Performance	N/A	*Grandparenting lasts until November 2017	25	45	65	65
Overarching, Collective Impact:	CHT Vendor	Quarterly	Percentage of CHTs employing Certified Community Health Workers	0	Number of CHTs with Certified CHWs	Number of CHTs	Providers	Process	Percentage	Performance	N/A	None	10%	50%	100%	100%
Patients with access to CHTs	EOHHS	Annual	Number of patients in provider panels with referral ties to SIM CHTs	0	Number of patients in	N/A	Patients	Structure	Count	Utilization	N/A	None	TBD	TBD	TBD	TBD

					practice panel											
Percent of RI residents with access to CHT	CHT vendor/ U.S. Census Bureau	Quarterly	Percent of RI residents with access to CHT (SIM funded + Existing)	8%	Number of patients in practice panel with referral ties to CHT	State Population	Statewide Population	Structure	Percentage	Utilization	N/A	85,300 patients are empaneled in	TBD	TBD	TBD	TBD
Reports from HealthFacts RI	DOH	Quarterly	# of publically available reports released from HealthFacts RI per year	0	Number of reports	N/A	Other	Process	Count	Other	N/A	None	6	6	6	6
Requests for data extracts from HealthFacts RI	DOH	Quarterly	# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year	0	Number of requests	N/A	Other	Process	Count	Other	N/A	None	10	10	10	10
Use of Common Provider Directory - State Agencies	RIQI/EOHHS	Quarterly	CUM # of state agencies using common provider directory	0	Number of agencies	N/A	State agencies	Structure	Count	Other	N/A	None	2	5	5	5
Use of Common Provider Directory - Health care organizations	RIQI	Quarterly	CUM # of private sector health care organizations using common provider directory	0	Number of health care organizations	N/A	Health Care Organizations	Structure	Count	Other	N/A	Includes payers, hospitals, and others organizations.	5	15	15	15
Provider organizations submitting data to the HCQMRFS	EOHHS	Quarterly	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.	0	Number of organizations sending data	N/A	Provider Organizations	Structure	Count	Other	N/A	Targets assume that the system will be piloted initially. If successful, access to the systme can be scaled.	0	5	10	>10

Provider organizations receiving aggregated and benchmarked data from the HCQMRFS	EOHHS	Quarterly	CUM # of health care organizations/practices recieving data from the Health Care Quality Measurement, Reporting and Feedback system.	0	Number of organizations receiving data	N/A	Provider Organizations	Structure	Count	Other	N/A	Targets assume that the system will be piloted initially. If successful, access to the systme can be scaled.	0	5	10	>10
Practices participating in the pediatric PCMH program	EOHHS	Annual	CUM # of practices participating in the pediatric PCMH program	0	Number of practices participating	N/A	Provider Organizations	Structure	Count	Utilization	N/A	None	9	9	9	9
Clinicians participating in the pediatric PCMH program	EOHHS	Annual	CUM # of clinicians participating in the pediatric PCMH program	0	Number of clinicians in participating practices	N/A	Providers	Structure	Count	Utilization	N/A	None	75	75	75	75
Patients attributed to practices participating in pediatric PCMH program	EOHHS	Annual	CUM # of patients attributed to practices participating in the pediatric PCMH prgram	0	Number of patients in participating practices	N/A	PCMH Enrollees	Structure	Count	Utilization	N/A	None	30000	30000	30000	30000
Practices with access to child psychiatry access program	Vendor	Quarterly	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services	0	Number of pediatric practices that have access	N/A	Provider Organizations	Structure	Count	Utilization	N/A	None	40	40	40	40
Pediatricians with access to child psychiatry access program	Vendor	Quarterly	CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services	0	Number of pediatricians who have access	N/A	Providers	Structure	Count	Utilization	N/A	None	200	200	200	200
Pediatricians who have received consultation services from child psychiatry access program	Vendor	Quarterly	CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services	0	Number of pediatricians who have receieved consultation services	N/A	Providers	Structure	Count	Utilization	N/A	None	100	150	200	200
Patients served under child psychiatry access program	Vendor	Quarterly	CUM # of patients served under the child psychiatry access program	0	Number of patients served	N/A	Patients	Structure	Count	Utilization	N/A	None	1500	4000	7500	7500

SBIRT Training	Vendor	Quarterly	CUM # of providers who have been trained in SBIRT	0	Number of providers trained	N/A	Providers	Process	Count	Performance	N/A	None	90	170	250	250
Integrated Behavioral Health Initiative	Vendor	Quarterly	CUM # of practice sites participating in integrated behavioral health initiative.	0	Number of practice sites participating in initiative	N/A	Providers	Structure	Count	Performance	N/A	None	12	12	0	12
CMHCs receiving provider coaching	Vendor	Quarterly	CUM # of CMHCs receiving provider coaching	0	Number of CMHCs receiving coaching	N/A	Provider Organizations	Process	Count	Performance	N/A	None	8	8	0	8
CMHCs with Care Management Dashboards	Vendor	Quarterly	CUM # of CMHCs with real-time ED and inpatient dashboards in use	0	Number of CMHCs with dashboard in use	N/A	Provider Organizations	Structure	Count	Performance	N/A	None	8	8	8	8
Providers trained to use care management dashboards at CMHCs	Vendor	Quarterly	CUM # of providers trained to use dashboards at CMHCs	0	Number of providers trained to use dashboards	N/A	Providers	Process	Count	Performance	N/A	None	80	100	120	120

Appendix 2: Assessment Measures & Additional Criteria

Part 1: Proposed Integrated Population Health Plan Metrics: Physical Health				
Metric/Survey Item	**Data Source**	**Population**	**SIM Measures Alignment**	**IPH Continuum**
Obesity				
About how much do you weigh without shoes?; About how tall are you without shoes?	BRFSS; YBRS	All Rhode Islanders		Prevention; Detection/Diagnosis
During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis
Proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities	BRFSS	All Rhode Islanders (older adults)		Prevention; Detection/Diagnosis
Adult Body Mass Index (BMI) Assessment	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Prevention; Detection/Diagnosis
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Child Core Set Measures	Prevention; Detection/Diagnosis; Treatment
Tobacco Use				
Tobacco Use: Screening and Cessation Intervention	Administrative claims, Electronic Clinical Data	RI commercial and public insurance population	Adult Core Set Measures	Detection/ Diagnosis; Treatment; Survivorship
Do you now smoke cigarettes every day, some days, or not at all?	BRFSS	All Rhode Islanders		Detection/Diagnosis
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?	BRFSS	All Rhode Islanders		Treatment; Survivorship

Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?	BRFSS	All Rhode Islanders		Detection/Diagnosis
Chronic Diseases				
Have you ever been told by a doctor or other health professional that you had angina or coronary heart disease?	BRFSS	All Rhode Islanders		Detection/Diagnosis
(Ever told) you that you had a heart attack also called a myocardial infarction?	BRFSS	All Rhode Islanders		Detection/Diagnosis
Other than during pregnancy, have you ever been told by a doctor or other health professional that you had hypertension, also called high blood pressure?	Population-Based Survey	All Rhode Islanders		Detection/Diagnosis
Cardiovascular disease mortality rate	Vital Statistics/Death Records	All Rhode Islanders		Survivorship/EOL Care
Chronic Condition Hospital Admission Composite—Prevention Quality Indicator	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	CORE ACO Measure Set	Treatment
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	MENU ACO Measure Set	Treatment
Comprehensive Diabetes Care: Eye Exam	Administrative claims, Electronic clinical data	RI commercial and public insurance population	MENU ACO Measure Set	Treatment

Comprehensive Diabetes Care: Medical Attention for Nephropathy	Administrative claims, Electronic clinical data	RI commercial and public insurance population	MENU ACO Measure Set	Treatment
Other than during pregnancy, have you EVER been told by a doctor or other health professional that you have diabetes or sugar diabetes?	BRFSS	All Rhode Islanders		Detection/Diagnosis
Is there one doctor or other health professional you usually see for your diabetes? Do not include specialists to whom you have been referred such as diabetes educators, dieticians or foot and eye doctors.	BRFSS	All Rhode Islanders		Treatment
Have you EVER been told by a doctor or other health professional that you have any of the following: prediabetes, impaired fasting glucose, impaired glucose tolerance, borderline diabetes, or high blood sugar?	BRFSS	All Rhode Islanders		Detection/Diagnosis
Have you had a test for high blood sugar or diabetes within the past three years?	BRFSS	All Rhode Islanders		Detection/Diagnosis
(Ever told) you had a stroke?	BRFSS	All Rhode Islanders		Detection/Diagnosis
Stroke mortality rate	Administrative claims	All Rhode Islanders		Survivorship/EOL Care

Part 2: Proposed Integrated Population Health Plan Metrics: Behavioral Health				
Metric/Survey Item	**Data Source**	**Population**	**SIM Measures Alignment**	**IPH Continuum**
Behavioral Health				
Screening for Clinical Depression and Follow-Up Plan	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment; Survivorship
Antidepressant Medication Management	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment; Survivorship
Adherence to Antipsychotics for Individuals with Schizophrenia	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Treatment; Survivorship
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Child Core Set Measures	Treatment; Survivorship
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Child Core Set Measures	Prevention; Treatment; Survivorship
Follow-Up after Hospitalization for Mental Illness (7-day)	Administrative claims, Electronic clinical data	RI commercial and public insurance population	CORE ACO Measure Set	Prevention; Treatment; Survivorship
30-day Psychiatric Inpatient Readmission	Administrative claims, Electronic clinical data	RI commercial and public insurance population	MENU ACO Measure Set	Prevention; Treatment; Survivorship
(Ever told) you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis
During the past 12 months, did you ever seriously consider attempting suicide?	YRBS	All Rhode Islanders		Prevention; Detection/Diagnosis
During the past 12 months, did you make a plan about how you would attempt suicide?	YRBS	All Rhode Islanders		Prevention; Detection/Diagnosis
Number of Adverse Family Experiences for child, of 9 asked about	YRBS; BRFSS ACE-Module	All Rhode Islanders		Prevention; Detection/Diagnosis

Suicide Rate	Death Records	All Rhode Islanders		End-of-life
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Diabetes Monitoring for People With Diabetes and Schizophrenia	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Administrative claims, Electronic clinical data	RI commercial and public insurance population		Prevention; Detection/Diagnosis; Treatment
Substance Abuse				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Administrative claims, Electronic clinical data	RI commercial and public insurance population	Adult Core Set Measures	Prevention; Detection/Diagnosis; Treatment
Have you ever used cocaine, crack cocaine, heroin, or methamphetamine?	NHANES	All Rhode Islanders		Prevention; Detection/Diagnosis
adults reporting use of any illicit drug during the past 30 days	NSDUH	All Rhode Islanders		Prevention; Detection/Diagnosis
high school students who report they ever used prescription drugs	NSDUH	All Rhode Islanders		Prevention; Detection/Diagnosis
overdose drug deaths	Vital statistics	All Rhode Islanders		Prevention; Detection/Diagnosis

Part 3: Proposed Integrated Population Health Plan Metrics: Additional Measures				
Metric/Survey Item	**Data Source**	**Population**	**SIM Measures Alignment**	**IPH Continuum**
Access to Healthcare				
Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Service?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Do you have one person you think of as your personal doctor or health care provider? (If "No" ask "Is there more than one or is there no person who you think of as your personal doctor or health care provider?".)	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
What type of care was delayed or not received? - Medical care	NHIS	All Rhode Islanders (those reporting financial hardship)		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
What type of care was delayed or not received? - Mental health services	NHIS	All Rhode Islanders (those reporting financial hardship)		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Health Related Quality of Life				
Would you say that in general your health is?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care

was your mental health not good?				
Metric/Survey Item	**Data Source**	**Population**	**SIM Measures Alignment**	**IPH Continuum**
Health Related Quality of life				
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Social Determinants of Health				
How often in the past 12 months would you say you were worried or stressed about having enough money to pay your rent/mortgage?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Are you Hispanic, Latino/a, or Spanish origin?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Which one of these groups would you say best represents your race?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
What is the highest grade or year of school you completed?	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care
Are you currently…? (Employment Status)	BRFSS	All Rhode Islanders		Prevention; Detection/Diagnosis; Treatment; Survivorship; End-of-life care

Part 4

Developing Population Health Metrics

✓	**RBA Step 1:**	**Population:** Identify the population you will be discussing
✓	**RBA Step 2:**	**Result:** Identify the specific result
✓	**RBA Step 3:**	**Indicator:** Identify data points that will measure your progress
✓	**RBA Step 4:**	**The Story Behind the Trend:** Identify what the indicators say, what the cause and forces are that affect these indicators
✓	**RBA Step 5:**	**Key Partnerships:** Identify partners with a role to play in turning the curve
✓	**RBA Step 6a:**	**Steps Toward Action:** Identify the 5 best ideas for Turning the Curve and improving the results
✓	**RBA Step 6b:**	**Strategies:** Identify which strategies are best suited to turning the curve in the areas identified above

Source: Institute of Medicine

Appendix 3: RIDOH Guiding Principles Letter

Nicole Alexander-Scott MD, MPH
Director

Department of Health
Three Capitol Hill
Providence, RI 02908-5097

TTY: 771
www.health.ri.gov

February 16, 2016

Victoria M. Almeida. Esq.
Chair, Health Services Council
c/o Adler Pollock & Sheehan P.C.
One Citizens Plaza, 8th Floor
Providence, RI 02903

Dear Chair Almeida:

As you know, the Health Services Council was recently reconstituted to examine applications from healthcare providers for certificates of need (CONs). Rhode Island law generally requires healthcare facilities to obtain a CON before opening new facilities or expanding existing facilities, and a similar process governs hospitals seeking to reduce primary or emergency care capabilities (so-called "reverse CON"). Rhode Island is one of approximately 37 states in the nation that maintains a CON requirement.

Over the last year, the Rhode Island Department of Health (the "Department") has set out three strategic priorities to guide all aspects of its operation, and to drive the actions that will improve the population's health. The Department's three leading priorities are to:

- Address social and environmental determinants of health,
- Eliminate disparities of health and promote health equity, and
- Ensure access to quality health services for all Rhode Islanders, including our vulnerable populations.

In lieu of a state health plan that should be available later in 2016, the Department will use a framework of guiding principles to evaluate the CON applications for this renewed legislated process. These guiding principles will be derived from the Department's three leading priorities, as well as the health reform goals expressed in the State Health Innovation Plan, the State Innovation Model (SIM) application, the reports of the Working Group for Reinventing Medicaid, the report of the Working Group for Healthcare Innovation, and the 2015 Rhode Island Department of Health (RIDOH) Statewide Health Inventory. In addition to the comprehensive data available for reference from the Health Care Planning and Accountability Advisory Council's hospital capacity study, primary care study, behavioral health study, and total cost of care study, the RIDOH 2015 Statewide Health Inventory, in particular, provides an unprecedented map of the healthcare landscape in Rhode Island, including data on hospitals, outpatient centers, long-term care, other facilities, and the patient community served, which will guide the Department's decision making in the CON process.

Guiding Principles

- **Needs of the population**
  The Department will evaluate a proposed new service for its ability to improve the health of Rhode Islanders in line with the Department's population health goals. In particular, the Department will evaluate the availability of the new service to the people of Rhode Island, including factors such as the volume and utilization in existing facilities which offer the service, as well as the strength of clinical evidence supporting the use of the service, national recommendations for availability of services per capita by type, and the expected benefit to population health. The extent to which new services effectively address social and environmental factors, which affect health outcomes, will be assessed. The Department will strive to limit and reduce excess capacity in services, particularly those that do not address the most important factors in the health of Rhode Islanders, especially those social and environmental elements.

- **Health reform goals**
  The Department will seek to align CON decisions with the state's broader health reform goals. Rhode Island's health reform goals are anchored by the triple aim of improved health outcomes, an enhanced patient experience of care, and a reduction in per-capita healthcare costs. CON applications will be reviewed in light of these aims and the extent to which the application affects any or all of them. In addition, through review of the state's health reform documents, the Department has identified the shift to alternative payment models, the establishment of systems of [illegible] the continued integration of physical and behavioral care, the maintenance of consumer choice, the improvement of health equity, the elimination of disparities of health by addressing structural factors which determine gaps in health outcomes, and the reduction in waste and overcapacity as further goals for the state. The Department expects that approved new services will align with these goals.

- **Quality**
  The Department will consider the ability of the applicant to provide high-quality services to the people of Rhode Island. Applicants will be expected to have strong quality records as demonstrated by performance measurement reports either in Rhode Island or elsewhere. These reports should include quality measures endorsed by national professional societies or national measure endorsement organizations, as applicable. In addition, the Department will consider whether the applicant has received recognition or accreditation from applicable national entities, depending on the type of services provided. The Department will take into account whether the new service will receive appropriate staffing, including the quantity, skill mix, and training of providers. New services should have sufficient volume to ensure physicians and other providers have ample experience to maintain skills to provide high-quality patient outcomes while not unduly adversely affecting the volume and quality of services delivered by extant providers.

- **Affordability**
  The Department will consider the ability of the state to afford the proposed service, with the goal of ensuring all Rhode Islanders have access to high-quality affordable care. In particular, the Department will evaluate the projected effect on health insurance expenses of

adding the new service, including the projected increase or decrease in health insurance premiums in the commercial market and the projected increase or decrease in state spending through the Medicaid program. In performing this analysis, the Department will consider the additional demand generated by new facilities and services as well as the benefits of shifting care to lower cost settings. In keeping with the goal of affordable healthcare with predictable costs, the Department will examine the likelihood of new services causing sudden significant increases in healthcare expenses.

- **Accessibility**
  The Department will consider the ability of the new service to improve health equity and eliminate disparities of health. The Department will also consider the benefits of improving access to care, relative to national standards of geographic adequacy, and the impact on public health outcomes. In particular, the Department will review the proposed service's role in improving the provision of care for underserved populations, including elders, people with disabilities, those without adequate education, Medicaid populations, underrepresented racial and ethnic groups, and others. Likewise, applicants should demonstrate how their proposal will help correct imbalances in the distribution of care, such as by assisting the underinsured who are disproportionately impacted by medical costs, ensuring that necessary support functions that address social and environmental factors are available, and by reducing the travel time to such essential services.

- **Innovation**
  The Department will seek opportunities to align new services with the broad goal of supporting innovation in healthcare, such as clinical research, professional education and training, and other academic activities. Innovation may also include the creation of new systems of care designed to pilot new delivery models, payment system reform, or other health reform goals aligned with the triple aim.

In addition to examining CON applications, the Health Services Council also reviews two other categories of applications: applications for initial licensure from new facilities that do not require a CON and applications for changes in effective control of existing licensed facilities. Additionally, the Department conducts an administrative review of both acquirers and acquirees under the Hospital Conversions Act for hospitals seeking changes in ownership and control through mergers or acquisitions. Although the statutory and regulatory criteria applied to these applications are distinctly different from the criteria applied to CON applications, the Department's decision-making process for these requests will remain rigorous in consideration of the data-driven guiding principles described above.

The Department looks forward to working with you and the Health Services Council on the Governor's shared goal of improving the state's healthcare system for all Rhode Islanders.

Sincerely,

Nicole Alexander-Scott, MD, MPH
Director

Appendix 4: Final Answers to CMS Questions on Version 2 of the RI SIM Operational Plan

M E M O R A N D U M

TO: **Marti Rosenberg, Rhode Island SIM Project Director**
Office of the Health Insurance Commissioner

FROM: **Georganne Kuberski, Project Officer**
Centers for Medicaid and Medicare Services

DATE: 06/23/2016

RE: Rhode Island SIM Operational Plan:
Appendix 4 -- Round Two Feedback Response/Round Three Questions

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RI, thank you for your thoughtful responses to the second round of SIM questions on your Operational Plan. Please find highlighted in yellow italics, additional questions from the SIM Team. The questions directly below are critical questions and information is required in order for the team to evaluate RI's readiness to move into Year One of SIM Testing.

We are happy to provide additional responses. We have flagged the responses with this color lighting, and all new language is in this Calibri font.

We also want to note that given Rhode Island's shared governance model for SIM, we operate in a fully transparent manner with our SIM Steering Committee and other interested parties – with the important exception of procurement activities with our state purchasing department. We share all of the Operational Plan documents and any additional clarifications with the Steering Committee. Since these documents are all publically available (e.g. posted on the EOHHS website), we need to refrain from detailing the specific deliverables and/or milestones that will be included in an RFP or single source contract. Although this may result in Rhode Island's Operational Plan including slightly fewer specifics than requested by CMMI, it is critical that we follow the purchasing rules so that we do not jeopardize our procurement processes. That would result in significantly more time needed to obtain qualified vendors to engage in the work.

Question 1:

RI stated that they are unable to provide specific information about their APMs because it is not yet public, but they will do so in their next Quarterly Report. However, most other states have articulated the APMs they are pursuing, as it is a crucial part of this strategy, what is RI able to share in order to assure the SIM Team the state is prepared to move into Test Year One of their SIM initiative?

Answer 1 (6.23.2016):

Medicaid is currently in the process of re-procuring its managed care contracts. This procurement process will include information on APM targets that will apply to Medicaid Managed Care Organizations (MCOs). At this time, procurement rules prohibit us from disclosing this information in a public document - however we can share that Medicaid is striving to align payment reform targets, payment models, and Patient Centered Medical Home (PCMH) strategies with those of OHIC, and that Medicaid's approach to value-based purchasing is aligned with SIM efforts and with OHIC's efforts on the commercial market side. We will be able to share specific details on the MCO targets when it is made public through our procurement process. We anticipate that the Medicaid RFP will be issued soon, in July, at which time we will forward you the relevant sections.

To further ensure that there is alignment across the Medicaid MCO contracts and OHIC's insurer targets, the state's review committee for this RFP will include a representative from OHIC. The state anticipates that the contracts will be awarded within six months of issuing the RFP and that the contracts will include the APM targets along with requiring the contracted entities to report specific data to the State relating to APMs.

Question 2:

RI stated that they are unable to provide an update on their sustainability approach for attaining a Medicaid match for their workforce development activities until their next Quarterly Report. This is the crux of your sustainability plan and workforce development; activities beyond the grant period would certainly be threatened if the state were unable to get matched funding. This is a critical issue for moving into Test Year One. TAs are happy to share examples of workforce sustainability efforts from other states that extend beyond a Medicaid match with Rhode Island if that would be helpful.

Answer 2 (6.23.2016):

We were previously unable to provide some specific information on the sustainability approach because we were still finalizing details. We can share that Rhode Island is awaiting CMS approval to implement a Category III Change to its Comprehensive 1115 Waiver Demonstration (project no. 11- W- 00242/1). Specifically, this waiver change seeks federal authority to claim federal matching funds for a variety of services, including certain state university and college health professional training program

expenditures specifically devoted to training the health workforce that will be needed to provide health care to Medicaid enrollees in a transformed delivery system.

This Designated State Health Program (DSHP) waiver, if approved, will generate an estimated $32.2 million for the first year and $147.5 million over five years to support Rhode Island's Health System Transformation Program (HSTP), which will focus on the development of provider-led Accountable Entities to help achieve Rhode Island's "Reinventing Medicaid" and Triple Aim objectives. DSHP funds will also provide significant on-going support for a state Healthcare Workforce Transformation initiative to address the workforce needs of our healthcare providers and workers and support the objectives of the HSTP. Rhode Island's Healthcare Workforce Transformation initiative will engage a diverse cross-section of healthcare educators, providers, and policy-makers to conduct a comprehensive healthcare workforce needs assessment, develop a strategic healthcare workforce transformation plan, and establish innovative and enduring programs and partnerships that will prepare the current and emerging workforce to meet the needs of an evolving health system. The DSHP waiver provides Rhode Island with a path to sustain its workforce development efforts beyond the life of the SIM grant.

Question 3:

The primary delivery system effort of RI's SIM program, its Care Transformation Collaborative, extends to only 5% of the state's population (58,000 of 1,055,000 residents). While we realize this is a pilot effort that could spread to other practices if it is successful, what is the plan for expanding this effort?

Answer 3 (6.23.2016)

First, we want to clarify the reach of Rhode Island's current delivery system reform efforts and plans for expanding these efforts. Then, we will specifically address the Integrated Behavioral Health program which will target reaching 58,000 participants.

Rhode Island's Current Delivery System Reform Efforts

Launched in 2008 by the Office of the Health Insurance Commissioner and co-convened by the Executive Office of Health and Human Services, the Care Transformation Collaborative of Rhode Island (formerly known as The Rhode Island Chronic Care Sustainability Initiative) brings together key health care stakeholders to promote care for patients with chronic illnesses through the patient-centered medical home (PCMH) model. CTC began with five pilot sites in 2008 and has grown to 81 practice sites with pediatric sites added in 2016. Currently, over 300,000 Rhode Islanders receive their care from practices participating in PCMH system reforms. The PCMH program is sustained through a multi-payer effort in the form of a per member per month contribution from the carriers based on attributed membership.

Plans for Expanding these Efforts

Rhode Island payers have applied for participation in CPC+, which, if accepted, will add new practices and patients to our care transformation totals. Our Medicaid program and several of our carriers have submitted CPC+ applications, and the state and CTC will be as supportive as they can be to facilitate CPC+ participation. The priorities in the payer applications align with the state's SIM efforts and with existing initiatives such as CTC and TCPI.

Integrated Behavioral Health Program
Because of the strength of our current practice transformation work, our SIM project decided to fund the smaller CTC-led Integrated Behavioral Health (IBH) program referenced above, with 58,000 participants. The SIM funds being used to pilot this IBH program will help us identify if there is a return on investment. If a ROI is realized, CTC, along with interested state agencies and the SIM team will work with the insurers to invest some of the savings into expanding the program to additional sites. OHIC and EOHHS will continue to identify potential regulatory levers to incent such an expansion.

BEHAVIORAL HEALTH INTEGRATION

1) **The plan has outlined a goal of on boarding 12 integrated behavioral health model practices by 2016 but later mentions 20.**

   In September, 2015, the Care Transformation Collaborative of Rhode Island (CTC) successfully applied to the Rhode Island Foundation and received funding to fully integrate behavioral health services into a set of primary care practices. CTC's original grant submission to the Rhode Island Foundation was for 50,000 lives and an estimated 20 practices. When the Rhode Island Foundation asked CTC to reduce the budget, CTC then cut back to 16 practices and 30,000 lives. As it turns out, CTC was able to reach 58,000 lives with all 12 practices that applied and were accepted into the pilot, surpassing the original proposed number of 50,000 lives. The 12 practices had a kick off meeting in January, 2016. (See Pages 160-161)

2) **What is the goal beyond 2016?**

   CTC will continue the three year pilot which kicked-off in January, 2016 with funding from the Rhode Island Foundation. By September 30, 2016, the 12 practices will receive orientation to the training and data collection project, which is being funded through SIM. Through the training and data collection activities, CTC expects to be able to demonstrate the business case for behavioral health integration into primary care practices, with some contribution from systems of care in alternative payment contracts or from health plans. (See pages 48-50, and 62)

3) **Will the selection of practices include geographic considerations (e.g., Northern RI, South County, etc.) to ensure adequate patient access to integrated care?**

Geography was not the primary consideration for this pilot effort. CTC was looking for commitment and readiness on the part of the practices to engage in the effort. Although geography was not the primary consideration, there is good cross-representation geographically**.** The locations of the 12 practices are: East Providence, Hope Valley, Johnston, Newport, Pawtucket (3), Providence (4), and Warwick. (See pages 48-50, and 62)

4) **As mentioned during the site visit, RI has a large percentage of small ("onesie") primary care provider practices. How will the state support small practices if they have interest and capacity in physical-behavioral health integration?**

   See question five below.

5) **Will there be opportunities to establish a consortium of onesie practices that may be paired with BH providers and infrastructure support to transform their practices?**

   Rhode Island sees several avenues for expanding the integration of behavioral health care into small primary care practices. Community Health Teams are being used to support some small practices in providing behavioral health care. Through the SIM project, we expect to learn significant lessons from the evaluation of the 12 primary care practices which are in the process of integrating behavioral health care. The findings of the evaluation will document best practices from larger practices that can be applied to small ones. The findings will be shared with the health care leaders who are members of the SIM Interagency Team and Steering Committee and who are influential in driving health care changes in Rhode Island. Our state is also seeing the emergence of Accountable Care Organizations and other coordination of care activities that are bringing primary care practices, including small practices, into closely aligned primary care networks.

PAYMENT MODELS

6) **The state mentions that the Office of the Health Insurance Commissioner has the authority to offer incentives and enforce VBP thresholds. However, it is unclear if state plans to use this authority to regulate plans in a particular way to achieve VBP goals, or is it something that it will consider.**

   The Leveraging Regulatory Authority section of the Operational Plan (page 184) describes regulations and policy initiatives that the Office of the Health Insurance Commissioner is currently implementing to require commercial insurers to meet annual targets for use of alternative payment models. OHIC promulgated regulations in February 2015, held stakeholder meetings in the spring and fall of 2015 to define alternative payment models and develop specific requirements for

insurers, and issued binding requirements around payment reform to which insurers will be held accountable.

Question 4:

The state mentioned that "OHIC issued binding requirements around payment reform to which insurers will be held accountable." Please list these binding requirements and describe when/how they will be implemented.

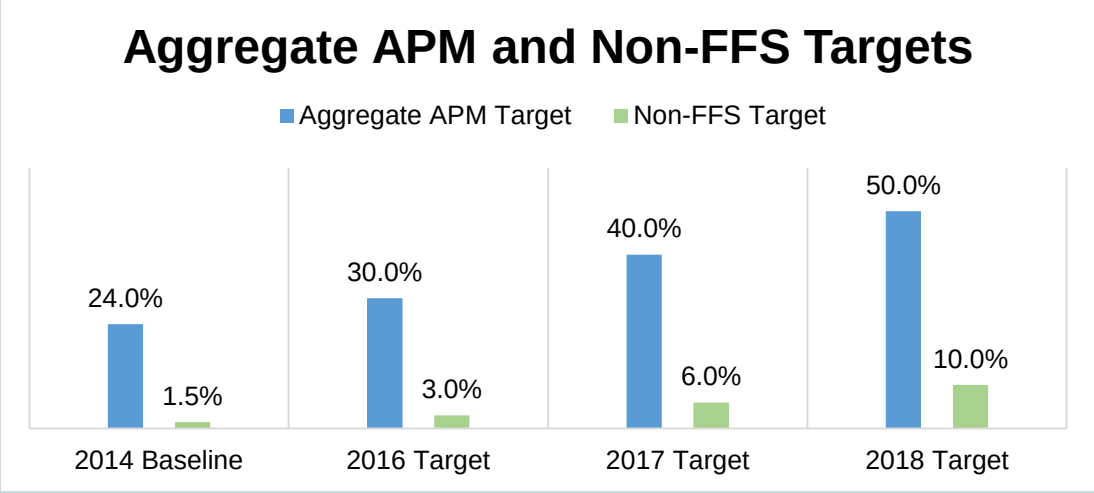
Answer 4 (6.23.2016)

OHIC's requirements around payment reform are described on Page 169 of our Operational Plan as "binding annual regulatory targets for commercial insurer use of APMs through 2018." Figure 46 on Page 169 (copied below) shows those targets through 2018.

OHIC is already requiring that commercial insurers meet these annual targets for use of alternative payment methodologies (APMs) and the Health Insurance Commissioner has issued **two binding APM Plans** for insurers to implement. Both plans are in effect now. (Please see the plans – especially Section 3 – which we have attached to the email through which we are sending this Memo.) In addition, the process of developing annual plans for insurers is specified in OHIC Regulation 2.

Insurers are currently implementing the requirements and OHIC will assess compliance with the annual requirements in conjunction with its annual premium rate review process. If a carrier is deemed non-compliant, the Commissioner will assess any or all penalties as specified under the Rhode Island general laws.

Figure 46: Rhode Island Commercial Payment Reform Targets



7) **The plan states that Rhode Island will use "incentives" and "enforcement" to achieve its VBP goals. While the OP mentions P4P as an incentive, it does not define particular "enforcement" strategies or regulations.**

In the Operational Plan, Rhode Island articulates a regulatory strategy to increase the use of alternative payment models among the state's commercial and Medicaid insurers. Pay for performance is a specific payment model that insurers may implement, and receive credit for, in achieving their payment reform targets. The Leveraging Regulatory Authority section of the Operational Plan (page 184) describe the specific enforcement strategies that the state will follow. For the commercial market, OHIC will leverage its prior approval rate review authority to hold insurers accountable for implementing alternative payment models and care transformation requirements that will lead to system transformation.

8) **Is there a specific strategy for engaging/including the state employee health plans and the self-insured (beyond the mentioned "spill over" effect)? It is unlikely the state will get to 80% VBP or 50% APM without engaging these insurers.**

The Operational Plan does not articulate a specific strategy for engaging self-insured plans. Policy leaders within state government are aware of the leverage for system transformation that is offered by the state employee health plan. As specific approaches to using this lever crystallize, Rhode Island will integrate these approaches into the SIM transformation plan components.

Question 5:

Including state employee health plans and self-insured populations in value-based payment efforts is imperative to reach 80% VBP and 50% APM goals. Rhode Island acknowledges this, but has not articulated a specific approach to engaging these populations, though it has indicated it plans to do so. Please outline detailed steps the state plans to take to arrive at these specific approaches, and if certain approaches are currently or will be under consideration, please indicate those as well.

Answer 5 (6.23.2016)

On Page 171 of the Operational Plan, we stated the following, based on data collected by OHIC in the winter of 2015:

"Baseline data on APM use in the commercial market in 2014 found that the percentage of medical payments made under an APM was roughly the same when evaluated over self-insured spend and fully insured spend. Therefore, we expect the effects of commercial insurance regulation with respect to health care payment models to have a spill-over effect on self-insured medical spend."

The SIM team sees engagement of self-insured groups in payment reform as a key strategy for advancing comprehensive health care system transformation through payment reform. Based on data from HealthFacts RI, we have identified the largest self-insured entities in Rhode Island (see chart below).

Entities in **bold** typeface are health care organizations that are already engaged in transformative initiatives and are represented on the SIM Steering Committee. In addition, the third party administrators for a majority of these employers are carriers who sit on the SIM Steering Committee. We will continue to work with these carriers, who will be able to bring the business case for APMs to their self-insured accounts.

Rhode Island Self-Insured Companies and Membership

Employer	**# Members**	**TPA**
Lifespan	18,000	**BCBSRI**
General Dynamics	10,000	**United**
CVS Health	6,500	**United**
Brown University	5,000	**BCBSRI**
SEIU Local 1199NE	3,500	**BCBSRI**
RI Laborers Union, Local 271	2,500	**BCBSRI**
Bank of America	2,500	Aetna
Metlife	2,500	**United**
Amica Mutual	2,200	**BCBSRI**
Johnson Wales University	2,000	**BCBSRI**
FM Global	2,000	**United**
Cox Enterprises	1,700	Aetna
Blue Cross Blue Shield of RI	1,700	**BCBSRI**
Hasbro	1,700	**United**
GTech Corp.	1,600	**United**
South County Hospital	1,600	**BCBSRI**

Landmark Medical Center	1,400	**United**
Providence College	1,300	**United**

Additionally, the Rhode Island State Employees Health Plan, which covers about 44,000 members, is an important lever toward our APM goals. The state health plan is currently administered by UnitedHealthcare and it participates in UnitedHealthcare's ACO shared savings program. To the extent a state employee is cared for by a practice in one of our three ACOs (Coastal Medicine, Lifespan, or the Rhode Island Primary Care Physicians Corporation), they are considered to be participating in the corresponding ACO program. As of March 31, 2016, 76% of State of Rhode Island members are attributed to an ACO or another population based program (such as the PCMHs through CTC).

QUALITY METRICS/MEASUREMENT

9) **It appears many of the performance metrics (as outlined in Appendix 2), as well as metrics for SIM components like patient engagement tools and advanced directives are still under development. Unclear if the timeline to develop those measures will align with CMMI's reporting requirements.**

The measures in Appendix 2 are geared for long-term population health measurement, which will likely not be affected by SIM. A small selection of population health outcomes related to SIM (approximately 3 measures) can likely be defined by Q2 of this year. We can include three to seven measure candidates for SIM Steering Committee approval (i.e., one for each health focus area). Measures related to patient engagement tools will be updated on an annual basis as priorities are identified by the workgroup to ensure alignment to the SIM Components and Transformation Wheel. As procurement for advanced illness care initiatives moves forward, tentative metrics will likely be ready by Q2.

Question 6:

Rhode Island commented that the measures in Appendix 2 are geared for long-term population health measures, likely not affected by SIM. However, CMMI requires that awardees report metrics that track cost, quality, utilization and population health on a quarterly and/or annual basis. Please indicate how these metrics will be reported throughout the test period.

Answer 6 (6.23.2016)

To clarify, the measures listed under Appendix 2 are specified for tracking implementation of our Integrated Population Health Plan. The metrics that Rhode Island will report to CMMI on a quarterly/annual basis, comprising model performance, model

participation, and payer participation metrics are listed in Appendix 1. Question 9, below, touches on our proposed cost measure. In terms of CMMI's proposed population health measures, please see response to question 7 below.

Question 7:

CMMI guidance recommends 3 model performance population health measures (tobacco use, screening and cessation intervention; screening for clinical depression and follow-up plan; and BMI screening and follow-up.) RI indicated that they would be able to identify population health measures by Q2 of this year (does that mean Q2 of Test Year 1? October?)

Answer 7 (6.23.2016)

Rhode Island does not currently have an integrated platform for compiling and measuring clinical quality data for all practices in the state. The Quality Measurement Reporting and Feedback System that will be funded by SIM will provide this platform in the future (see Page 236 of the Operational Plan). In the meantime, we intend, with CMMI approval, to report data on five clinical quality measures currently being reported by PCMHs in the state. While this approach does not provide a statewide number, it does represent clinical quality performance for patients who receive their care in PCMHs, which are an important component of Rhode Island's delivery system transformation strategy. The measures are:

Adults:

- Tobacco Use: Screening and Cessation Intervention
- Adult Body Mass Index Assessment
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (<8.0%)
- Screening for Clinical Depression and Follow-Up Plan

Pediatric:

- Body Mass Index Assessment for Children/Adolescents

In October 2016 OHIC will compile numerators and denominators for these metrics from existing PCMHs to collect baseline performance data and then we will track the data annually. As more practices begin to transform, the coverage of these metrics will expand.

Question 8:

If the state is choosing to not report on the 3 recommended measures, please explain why alternative measures will be selected (e.g. how the chosen measures will align better with their SIM work).

Answer 8 (6.23.2016)

Please see our response to question 7 above.

10) **CMMI reporting guidance recommends a quality metric related to experience of care - did not see that included in RI's core SIM metrics.**

Rhode Island will add metrics related to patient experience in PCMHs and hospitals using data from CTC-RI and publically available sources, such as survey data from CAHPS.

Question #9:

One of the CMMI recommended metrics around model performance cost is "Cost of care: total cost of care population-based per member per month" (see CMMI Round 2 Reporting Metrics Guidance). RI has proposed a cost metric of "Insured Claims Trend (PMPY)". Please explain why this measure was chosen instead of the recommended TCOC measure.

Answer #9 (6.23.2016):

Rhode Island SIM selected "Insured Claims Trend (PMPY)" instead of the measure recommended by CMMI because it aligns better with ongoing statewide discussions around health care cost containment. The Governor's Working Group for Healthcare Innovation discussed the establishment of an annual target for medical expense growth that aligned with the state's long-run average rate of economic growth (3.5%). Insured Claims Trend better reflects constructs for cost measurement that came out of the Working Group's discussion. In addition, the Insured Claims Trend metric is easier to determine using HealthFacts RI (the state's APCD).

While we would prefer this metric, we are willing to use the metric specified in the CMMI Round 2 Reporting Metrics Guidance, if CMMI feels strongly that it is important that we do so.

11) **It is unclear if RI will be able to report payer participation metrics by individual payer or whether it will be an aggregate of all payers by payment category.**

Rhode Island anticipated reporting aggregate data across payers within two market segments: commercial fully insured and Medicaid managed care. However, Rhode Island can, and will, report by individual payers as requested by CMMI.

12) **Metrics included in the driver diagram are not always consistent with metrics included in Core Metrics or Appendix 1 (e.g. Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare and Percentage of patients referred to and seen by**

applicable CHTs who received an annual influenza vaccination were metrics listed on driver diagram, but nowhere else).

The SIM team has cross walked the Core Metrics (Pages 20-24), Budget Table (Pages 35-39), Component Summary Table (Pages 59-67), Appendix 1 (Pages 266-272), and the Driver Diagram (Page 13-18) for consistency. We did not see a discrepancy with the CHT figures. We will continue to check these numbers and correct any discrepancies that we see.

WORKFORCE DEVELOPMENT

13) **There is a robust plan to train and certify CHWs and conduct an inventory of the workforce. However, how will the state create standardization for other largely unregulated positions (e.g. navigators, peers, etc.) that interact with health care integration efforts throughout RI?**

The state is not responsible for standardizing unregulated positions, but supports specific industry endeavors to do so, when applicable. For example, the RI Department of Health recently supported the efforts of healthcare providers and other stakeholders to develop certification standards for Community Health Workers (CHWs) through the RI Certification Board (a non-profit organization). Navigators and Peer Resource Specialists are identified within the Operational Plan as general CHWs and certain other unregulated occupations with additional certification (e.g., Diabetes Prevention Coach) are considered to be specialty CHWs. The RI Certification Board also certifies Peer Recovery Specialists and Prevention Specialists.

The certification process recently completed for CHWs may serve as a model for the potential certification of other unregulated occupations, as warranted by the labor market and/or recommended by a given industry. This process could include some or all of the following:

- Convene stakeholders (including employers, educators, and workers);
- Assesses the current number and type of "unregulated occupations," the scope of work, and type of training & education necessary;
- Review approaches taken by other states;
- Develop consensus on practice standards;
- Determine the pros and cons of certification and/or licensure (e.g., raising standards versus creating barriers to practice);
- Determine a path to certification;
- Consider the pros and cons of "grandfathering;" and
- Determine career pathways to and from the "unregulated position"

What financing mechanisms will the state explore to ensure sustainability or service delivery?

The interaction between CHWs and the healthcare setting is already ongoing formally through existing teams and informally within specialty care environments (e.g., oncology). Creating a development ladder for CHWs (to certified CHWs and then specialty CHWs) provides a mechanism for advancement and continued engagement in the field for an individual, similar to that in the clinical setting. This linkage could be influenced by a broader Federal emphasis on how addressing other determinants of health while addressing transformation can affect the healthcare cost trend. Smarter spending and smarter investing could play a role in assisting with addressing these determinants in a new way.

Service delivery using this type of resource is derived from the developing relationship between the healthcare setting and community setting within Rhode Island. The goal is to highlight the professionalism and importance of this work in Rhode Island and evaluate sustainable ways in which work performed by a CHW can be incorporated into more places within the healthcare sector once ROI is evaluated. The healthcare system's desire to employ certified CHW services and address determinants of health more broadly may ultimately be determined based on developing industry standards and ROI evaluation through SIM.

14) **The sustainability strategy for workforce development is obtaining a Medicaid match. Does the state plan on seeking federal match through a SPA for specific reimbursable activities, seeking authorization for additional CPT codes, etc.? It would help to have additional detail and timelines.**

The state is assessing the possibility of receiving Medicaid match of state investments in healthcare workforce education for workforce development activities and will provide an update in our next SIM Quarterly Grant Report.

In addition, how does RI plan to ensure the workforce is adequately prepared to address the physical and behavioral health needs of patients and pipeline for the future?

SIM recognizes the need to increase the behavioral health (BH) capacity of primary care providers, as well as the physical health (PH) capacity of BH providers. To this end, SIM intends to invest in several practice transformation activities that will increase this capacity and integration. SIM will also work closely with healthcare providers and educators to identify ways to increase the interdisciplinary (i.e., BH and PH) training of current and future healthcare workers.

15) **For Practice Coaching at Community Mental Health Centers (Pg. 69), how will other provider practices outside of the CMHCs be included in this training and sustainability strategy?**

How will the state build upon and expand from the TCPI work underway by RIQI to support primary care practice transformation (outside of CHTs and CMHCs)?

Our Practice Coaching program is being specifically created for our Community Mental Health Centers, because of the great need that the Centers have to build their capacity to engage in a value-based care paradigm. We are also focusing on practice transformation and investments in our workforce with our Community Health Teams, SBIRT, and with our Reporting and Feedback System (which will include practice training to use the system). We know that our SIM resources are limited and will not allow us to carry out all the practice transformation that we want to accomplish.

This is why we are pleased to be working in partnership with the Rhode Island Quality Institute (RIQI), which runs Rhode Island's TCPI program. As noted on Page 243, SIM is a participant in the Provider Practice Transformation Workgroup coordinated by RIQI, Healthcentric Advisors, and CTC. In order not to duplicate work that is funded by other federal initiatives, these organizations are communicating about and coordinating all of the efforts that touch provider practices. And because we know that these organizations are working with primary care physicians, specialists, and long-term care, SIM is focusing practice transformation specifically on CHTs and CMHCs.

In particular, regarding TCPI: RIQI is an expert with many years' experience in practice transformation, and can focus their transformation activities to support SIM. In order to further build on this opportunity, we will be including RIQIs practice transformation staff in more activities, including having the Director for RIQI's Center for Improvement Science, Darlene Morris, participate in our interagency staff meetings.

PRACTICE TRANSFORMATION

16) **Under the practice transformation fund of $7.1 million, will practices have access to funds to assist with the up-front costs of HIT infrastructure, staffing, etc?**

The $7.1 million of practice transformation in the SIM budget does not include money for up-front costs of HIT infrastructure. The state is exploring support through the Medicaid HIT I-APD.

PATIENT ENGAGEMENT

17) **How will the RI SIM team engage consumers in the development of patient engagement priorities and needs to ensure patient-centered care?**

The patient sits at the center of the SIM wheel as the focal point of all of our activities and even more so at the heart of the Patient Engagement Workgroup. The workgroup has representatives from various entities and providers who represent patients. These subject-matter experts, including those who are community-based and offer home visits and/or self-management programs, are critical to determining priorities. The group also includes a representative from the Commission for the Deaf and Hard of Hearing and from parent organizations, such as the Parent Support Network, and the Rhode Island Parent information Network. We will work with these organizations and others to learn from their constituencies – and would be eager to see if these organizations submit RFPs to have SIM fund activities that include direct consumer engagement with their members.

EVALUATION

18) **What is the timeline for rolling out their specific plans? The evaluator will be interested in what data are available and when so as to know how to allocated time and resources. For example, it's not clear when or where changes in MCO contracts will come into fruition (p.182) to pay for APMs.**
    - **Are these state-wide?**
    - **Are these to happen in 2016? 2017? A different date?**

Please see our Master Timeline for the months where we aim to implement our programs. We will finalize our overall evaluation plan upon procurement of the evaluation vendor in Q1-Q3. Individual investments in evaluation will be adjusted upon negotiation of scopes of work and contracts with chosen vendors throughout Year 2.

The SIM Steering Committee met on Thursday, June 9 to discuss evaluation from a milestone perspective. A broader view of success within the context of the SIM Transformation Wheel and concrete milestones (including some outputs) are now being incorporated into the evaluation planning efforts.

At this time, we are unable to share specific information about APMs because it is not public, but we will provide this to you in our next SIM Quarterly Report.

Question 10:

The question above from CMS should have stated the "federal evaluator". The concern of CMS lies in how, where, and when particular models are implemented to ensure a fair and appropriate evaluation. What information

can the state provide at this time for these concerns regarding cooperation with the federal evaluation (as delineated in their terms and conditions)?

Answer 10 (6.23.2016)

First, Rhode Island SIM is fully committed to cooperating with CMMI's federal evaluator to assure a fair and appropriate evaluation. We recently participated in a three-day site visit with RTI and were able to share all of the data that they required, by their deadline.

In terms of sharing information about our model implementation, we would direct you to our updated timeline, where we have laid out when we aim to get RFPs and single source requests to the Rhode Island purchasing department. Our purchasing department has strict rules about what we can share about procurements before they are made public.

However, we want to share our procurement process with you, so you can understand how we will make decisions about the models that we will fund. The SIM Steering Committee and other stakeholders from our SIM Workgroups have had input on the content components of the activities that we will fund. These stakeholders can continue to provide general suggestions and advice before the RFP is formally drafted, and we have taken advantage of their subject matter expertise to help create the models that we are funding.

For all RFPs and single source proposals, state staff (in this case, the SIM staff team) drafts the RFP document that reflects the input gathered and other research that we have carried out. As we draft the documents, we aim to strike a balance between laying out our specific requirements – the goals we want the vendors to reach and the timeline in which we want the work done – with the ability for the applicant to give us a creative response to the RFP and to present a timeline that they think is achievable.

For each RFP, we will establish an interagency review committee. In some cases, SIM staff may seek to identify a SIM steering committee member or expert in the community who can serve as a subject matter expert and advise the review committee. Such individuals cannot work for an organization that is responding to that RFP and is required to sign a non-disclosure agreement. This process allows the state to leverage our SIM shared governance structure.

Therefore, for those program activities that are in the RFP process, we have identified the transformation model to be implemented and will be refining the project deliverables (as described throughout our Operational Plan), but we will need to wait until the RFP process is finalized to give the federal evaluators all of the details. Again, we are fully committed to sharing all of the detailed model information with RTI and CMMI as soon as it is ready.

19) **In general, the plan needs more detail around intermediate milestones. PCMH kids provides an example. The plan lacks clarity how/where/when this program is implemented.**

We will identify intermediate milestones for our plans through our procurement process. Within each of our contracts, we will clearly define deliverables and associated dates that can be used to assess progression. Each procurement will have contract managers to ensure adherence to contract deliverables and milestones. We will continue to provide you with further detail regarding intermediate milestones as we move through the procurement process and secure our vendors.

Question 11:

For such a procurement to be possible, any vendor would need to be instructed by the buyer as to when/how/where to roll out a program. In this case, the buyer is the state. To direct the contractor, the state will need have developed milestones and goals. These will materialize in contract documents for bidders to respond to the state. CMS will review these documents and process as part of the cooperative agreement. Thus, can the state share information regarding milestones with CMS at this time?

Answer 11 (6.23.2016)

This answer aligns with the answer to question 10 above. We have added in a number of intermediate milestones to the latest version of our Master Timeline (which we have attached to the email through which we are sending this Memo). Then, additional specific milestones of timing and implementation will be negotiated with our vendors during the procurement process. Once these milestones are in place, we will update the timeline and share it with the federal evaluators, CMS, and all stakeholders.

20) Provide additional explanation on how Rhode Island will coordinate the HIE and APCD governance.

Question 12:

The state included a note that "because of state privacy laws, there cannot be coordination between CurrentCare and the APCD governance." We are not asking that the state consider violating state law. The motivation for this question comes from the fact that we believe that the ultimate goal of linking/combining/aggregating claims and clinical information is critical to advancing the goals of delivery system reform. The combining of such information is important for providers to be successful in their efforts to improve quality and reduce costs. ONC has spoken with the state about this in the past and we believe we are in agreement that the state is strategizing to eventually create the ability to have linked (or aggregated) claims and clinical data to support providers in APMs (e.g., the statewide provider directory will support this). Our question was on this general topic. We would like to know what the state's plans are for that ultimate necessary state of being able to combine/link/aggregate claims and clinical data and how the APCD and HIE

play into that strategy. We continue to think that this is a critical issue. We think that if the state acknowledge this goal, stated that it is planning in this area, and stated that it would work with ONC to develop such planning throughout the year, that would be a satisfactory response. However, we welcome additional detail and/or pointers to other parts of the plan where this may have been mentioned.

Answer #12 (6.23.2016):

Rhode Island is currently coordinating governance for HIT development statewide through collaboration of "State Agency Principals" at RIDOH, EOHHS, and OHIC. We misspoke in saying that the State cannot coordinate the governance of HealthFacts RI (the APCD) and the HIE. Indeed, Rhode Island incorporates the community in the governance for the statewide HIT effort through both the SIM Steering Committee and RIQI Board meetings. Both entities include healthcare leaders and State Principals.

Rhode Island has distinct laws and statutory requirements governing the development, use and release of data from HealthFacts RI and the statewide HIE. However, Rhode Island laws make linking the two databases challenging and require each system to have its own community based commission. Both commissions are required to advise the Director of Health, which does allow the Director to create a coordinated strategy out of what would otherwise appear to be separate silos. While the specific focus and tasks for each committee differs, Rhode Island's strategy and criteria for data use (as permitted by law) are similar. The State's aligned data strategies help coordinate the HIT governance across these and other efforts. Moreover, the same state staff are responsible for both HealthFacts RI and the HIE, giving staff a broader understanding of the current HIT effort, and leveraging the synergistic potential of the two programs.

The State recognizes the benefits of directly linking HealthFacts RI data with the HIE data. Currently, HealthFacts RI has only de-identified data, which can only be released as such. The HIE data is identifiable but can only be shared to support treatment and coordination of care or for public health purposes. These constraints inhibit SIM's ability to link these two specific databases.

(As background, combining HealthFacts RI claims data with clinical data is a slow process. HealthFacts RI receives claims data that is already one quarter old. Rhode Island's aggregation vendor processes it with value-added analytics components and returns the now six-month old data to state analysts. State analysts consider the data to be a good representation after about nine months, which is due to claims run-out. Combining claims data with clinical data after nine months, provides a historical value to providers, but is not useful for real time patient management.)

Despite the challenges, state and RIQI staff have begun to identify potential ways to address this need. Rhode Island continues to explore implementing options such as:

1. Adding an extract of CurrentCare data to HealthFacts RI by sending it through the lockbox vendor, de-identifying it, and adding it to HealthFacts RI's analytics tool and extracts.
2. Amending state laws to reflect the needs and requests of providers throughout the state to deliver thoughtful value-based care in APMs.
3. As stated above and with the agreement of the payers and providers, building a separate system that shares data between payers and providers under HIPAA compliant business associate agreements.

To move ahead and make these critical decisions, we will depend on our stakeholders for input and advice. The most effective way to seek this advice will be for us to hold two or more educational forums to which we can invite members of the CurrentCare and HealthFacts RI oversight boards, and SIM's Technology workgroup. We will use these forums to have the experts in attendance review the options and make recommendations to the appropriate bodies – the HIE and HealthFacts RI Advisory Commissions, the SIM Steering Committee or state leaders. We have also planned several state interagency meetings with department leadership over the next year in order to decide our state strategy options.

Rhode Island is committed to improving the value of our statewide HIT infrastructure while serving the values of our resident, and we look forward to working closely with ONC and CMS to discuss ideas as we plan those meetings and move forward.

For additional information, contact:

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